

National Counselor Exam

Study Manual

IPGA - Institute for Personal Growth and Achievement

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Before You Begin...

Congratulations on reaching the professional level where licensing is within your reach! Your decision to become a National Certified Counselor, and to join thousands of other professional counselors in the advancement of our profession, is commendable.

IPGA believes that the best approach to the study process is to identify your strengths and weaknesses and then formulate a structured study plan incorporating **numerous repetitive passes** through the materials found in each chapter. How much time you spend on any one of the chapters in the study process depends upon your own assessment of your needs.

The Study Manual is updated and reprinted periodically to reflect changes and revisions in the counseling literature and announced changes in the NCE Exam.

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Please keep in mind that this Study Manual is not an attempt to teach new material, but to revisit the topics and issues that were part of your graduate level course work.

Please tell your friends about IPGA's comprehensive *NCE Exam Study Manual*.

The Staff of IPGA

Taking the Exam

All of the Exam questions will be multiple-choice questions as illustrated below:

1. A bottle of hand cream is laced with an irritant that causes itching. The young lady that uses the hand cream begins to scratch frantically. On subsequent occasions she is presented with other bottles of hand cream that have also been laced with the irritant. Eventually, the mere sight of the hand cream bottle is sufficient to make her scratch. In this example, the lady's scratching in response to the sight of the hand cream is
 - a. an unconditioned response (UCR).
 - b. **a conditioned response (CR).**
 - c. an unconditioned stimulus (UCS).
 - d. a conditioned stimulus (CS).

2. Jerry's family is a high income family consisting of his father, Bill; his mother, Susan; and two twin younger sisters, Janette and Keri. Jerry is 17 and is 7 years older than his sisters. Recently, though it's been going on for long time, his parents have been arguing over how Bill is spending (wasting according to Susan) significant dollars on lottery tickets. Jerry has begun to stay away from home more and more to avoid the fighting. His father, though, sees Jerry's staying out late as very poor decision making and is continually riding Jerry to come home earlier. Soon after Bill begins this, Susan joins in the attempt to get Jerry to act responsibly. Soon Bill and Susan are no longer fighting over Bill's expenditures on lottery tickets. When this family finally decides to seek therapy because of Jerry's behavior, which of the following terms would most likely be used to describe these three's relationship?
 - a. **triangulation.**
 - b. transfer of blame.
 - c. transference.
 - d. transactional disorder.

Be sure to read each question carefully. While several of the possible answers may be partially correct, you must select the **best possible answer** to each question.

There is no penalty for guessing (In other words, don't leave any question un-answered). If you can narrow the choice of four answers down to three or even two logical possibilities, you have a better chance of making an educated guess and picking the right answer. Don't forget that on this exam, it is as important to be able to rule-out incorrect answers as it is to select the correct answer. Be sure to answer all questions, even the one's you have to guess at! If a question is left blank, it is considered incorrect.

The Day of the Exam

Come prepared!! Be on time with reading glasses and medication if necessary. Be sure to take the appropriate and REQUIRED forms of identification with you. (These forms of identification and other important information are found in the packet NBCC mails you.)

You will probably also want to have a watch so you can budget your time. The use of dictionaries, study books, papers, computers, calculators, etc., are not allowed. IPGA suggests that you leave all study material or other reference materials at home.

Relax, and continue to relax as you progress through the examination. You'll do much better if you pay attention to your stress level and thereby know when to intentionally reduce your stress.

of Questions in order of IPGA Chapters*

Number of Questions In Each Chapter Test

		# of PRIMARY/ MAIN Questions from The Core Area*	# of ITEM ANALYSIS*** questions from The Core Area*
1	Human Growth & Development - 12 Questions*		
	Chapter 1 - Normal Human Growth & Development	6**	1**
	Chapter 2 - Abnormal Human Behavior	6**	1**
2	Research & Program Evaluation - 16 Questions*		
	Chapter 3 - Research Methods and Statistics	16*	4**
3	Appraisal - 20 Questions*		
	Chapter 4 - Appraisal or Assessment Techniques	20*	5**
4	Helping Relationships - 36 Questions*		
	Chapter 5 - Counseling Theories, Methods, & Techniques	20**	6**
	Chapter 6 - Consultation	6**	1**
	Chapter 7 - Family Therapy	10**	3**
5	Group Work - 16 Questions*		
	Chapter 8 - Group Dynamics, Theories, & Techniques	16*	4**
6	Professional Orientation and Ethics - 29 Questions*		
	Chapter 9 - Professional Orientation & Ethics	17**	5**
	Chapter 10 - Referral/Triage/Advocacy	6**	1**
	Chapter 11 - Supervision*	6**	1**
7	Career & Lifestyle Development - 20 Questions*		
	Chapter 12 - Lifestyle and Career	20*	5**
8	Social & Cultural Foundations - 11 Questions*		
	Chapter 13 - Social & Cultural Foundations	11*	3**
		160	40

of Questions by the 5 Counselor Work Behavior Areas*

- 1 Fundamentals of Counseling - 64 Questions
- 2 Assessment and Career Counseling - 22 Questions
- 3 Group Counseling - 19 Questions
- 4 Programmatic and Clinical Interventions - 26 Questions
- 5 Professional Practice Issues - 29 Questions

*This information is based on information provided by NBCC printed materials and Grade Sheets/Scoring Sheets

**This information is based on IPGA's "best guess" based on NBCC information.

***ITEM ANALYSIS questions are questions the board is "field testing" to determine whether or not to include them in future exams. There are 40 ITEM ANALYSIS questions on the NCE Exam.

Recommended Study Plan

I. GETTING STARTED

1. Take your **1st Full Exam** in the **Simulated Mode** (as opposed to the Study Mode — see step 6 below for a brief description of the Study Mode).
- 2A. When you are finished with this 1st Full Exam, the “Exam Summary/Question Summary” page appears. Using the chart below, write the lowest “% correct” and corresponding chapter name in the first row, then the next lowest % correct and corresponding chapter name in the 2nd row. Continue this process until you write the highest % correct and the corresponding chapter name in the 13th row.

Write in **YOUR SCORES** here:

	Scores	Study Manual's Chapter Number and/or Name
1	_____ %	
2	_____ %	
3	_____ %	
4	_____ %	
5	_____ %	
6	_____ %	
7	_____ %	
8	_____ %	
9	_____ %	
10	_____ %	
11	_____ %	
12	_____ %	
13	_____ %	

Example Only:

	Scores	Study Manual's Chapter Number and/or Name
1	31 %	4 - Abnormal Human Behavior
2	34 %	3 - Appraisal or Assessment Techniques
3	37 %	5 - Counseling Theories, Methods & Techniques
4	41 %	9 - Lifestyle and Career Development
5	47 %	12 - Consultation
6	48 %	10 - Social and Cultural Foundations
7	50 %	6 - Family Therapy
8	51 %	7 - Group Dynamics, Theories, Techniques
9	53 %	1 - Normal Human Growth and Development
10	57 %	13 - Supervision
11	57 %	8 - Professional Orientation
12	59 %	2 - Research Methods and Statistical Studies
13	63 %	11 - Referral/Triage/Advocacy

- 2B. You now have a rank-order list of your strengths and weaknesses. The **Recommended Study Plan** is based on reviewing the material at different levels, spending more in-depth study in your “weaker” areas and less in-depth study of your “stronger” areas.
3. If you purchased the Complete Study Package, it is now time to cover the **Critical Test Data** component, the **Recommended Study Plan** section, the **Essential Information** segment, the **Research & Stats** component, and the **Study Manual Overview** information. **It is STRONGLY RECOMMENDED that you review Critical Test Data, the last page of the Recommended Study Plan, and the Essential Information materials THREE OR FOUR TIMES! Yes!! They are that important!!!**

There are questions contained in the Online Testing System THAT REFER TO INFORMATION NOT COVERED IN THE MANUAL.

That is by design! It's to do two things:

1. To prepare you for the actual Exam when you see information that you've not seen before (such as the 40 Pilot Questions on every exam). When you come to these questions, **ANSWER THEM THE BEST YOU CAN** using the test-taking tips and strategies and go on. There is no need to search out other sources for the answers to these item analysis questions. **THEY ARE NOT INCLUDED IN YOUR GRADE!!**
2. To keep you from going on "auto-pilot" as you take the Chapter Tests and Simulated Exams.

REVIEW NUMBER ONE

4. Skim each chapter's outline and content in the Study Manual.
5. Take a Chapter Test immediately after your review of each Chapter (13 Chapter Tests – one for each chapter).
6. After reviewing all thirteen (13) chapters, take your **2nd Full Exam** and arrange your scores from weakest to strongest. The **Study Mode** (*as opposed to the previously mentioned Simulated Mode*) allows you to see **correct/incorrect answers** as you go. Some prefer this option either now or at some point in their study. **As in the Simulated Mode, the Study Mode** allows you to "Bookmark this Question" which enables you to return to this question (Bookmarked Questions appear again at the end of the Exam/Chapter Test) before you end your Exam (or Chapter Test). Additionally, the **Study Mode labels Pilot/Item Analysis Questions as such on the screen** – Pilot Questions (on the actual exam) are questions being "field tested" for use in future exams.
PLEASE NOTE: You can review all questions from your immediately previous Exam/Chapter test by clicking on the "My Purchases" link and then clicking on "Review Tests" (for Chapter Tests) or "Review Exams" (for Full Exams). Correct answers and Pilot Questions are demarcated as well.

	Scores	Study Manual's Chapter Number and/or Name
1	_____ %	
2	_____ %	
3	_____ %	
4	_____ %	
5	_____ %	
6	_____ %	
7	_____ %	
8	_____ %	
9	_____ %	
10	_____ %	
11	_____ %	
12	_____ %	
13	_____ %	

REVIEW NUMBER TWO

- 7. Repeat steps 4 and 5.
- 8. After reviewing all thirteen (13) chapters, take your **3rd Full Exam** and arrange your scores from weakest to strongest.

	Scores	Study Manual's Chapter Number and/or Name
1	_____ %	
2	_____ %	
3	_____ %	
4	_____ %	
5	_____ %	
6	_____ %	
7	_____ %	
8	_____ %	
9	_____ %	
10	_____ %	
11	_____ %	
12	_____ %	
13	_____ %	

REVIEW NUMBER THREE

- 9. Repeat steps 4 and 5.
- 10. After reviewing all thirteen (13) chapters, take your **4th Full Exam** and arrange your scores from weakest to strongest.

	Scores	Study Manual's Chapter Number and/or Name
1	_____ %	
2	_____ %	
3	_____ %	
4	_____ %	
5	_____ %	
6	_____ %	
7	_____ %	
8	_____ %	
9	_____ %	
10	_____ %	
11	_____ %	
12	_____ %	
13	_____ %	

REVIEW NUMBER FOUR

- 11-A. For every score below the Median (Middle), read in-depth that chapter in the Study Manual and immediately take a chapter test.
- 11-B. For every score above the Median (Middle), scan the chapter outline and chapter contents and immediately take a chapter test.
12. After reviewing all thirteen (13) chapters, take your **5th Full Exam** and arrange your scores from weakest to strongest.

	Scores	Study Manual's Chapter Number and/or Name
1	_____ %	
2	_____ %	
3	_____ %	
4	_____ %	
5	_____ %	
6	_____ %	
7	_____ %	
8	_____ %	
9	_____ %	
10	_____ %	
11	_____ %	
12	_____ %	
13	_____ %	

REVIEW NUMBER FIVE

13. Repeat step 11.
14. After reviewing all thirteen (13) chapters, take your **6th Full Exam** and arrange your scores from weakest to strongest.

	Scores	Study Manual's Chapter Number and/or Name
1	_____ %	
2	_____ %	
3	_____ %	
4	_____ %	
5	_____ %	
6	_____ %	
7	_____ %	
8	_____ %	
9	_____ %	
10	_____ %	
11	_____ %	
12	_____ %	
13	_____ %	

REVIEW NUMBER SIX

15. Repeat step 11.
16. Take your **7th and final Full Exam** as a Post-Test.

	Scores	Study Manual's Chapter Number and/or Name
1	_____ %	
2	_____ %	
3	_____ %	
4	_____ %	
5	_____ %	
6	_____ %	
7	_____ %	
8	_____ %	
9	_____ %	
10	_____ %	
11	_____ %	
12	_____ %	
13	_____ %	
14	_____ %	

II. Engage yourself in the material via action-oriented study.

- (a) Highlight chapters in different colors
- (b) Outline the materials
- (c) Handwrite the materials
- (d) Make flash cards
- (e) Store each chapter in a different room/location of house
- (f) Smell same smell while studying and when starting the actual exam
- (g) Read the material out-loud.

III. As part of your study plan, use positive imaging and self-talk to assist you in passing. See yourself passing the examination...holding your official PASSING Score Sheet. See yourself as you hold your first set of business cards with NCC/LPC/LPCC/LCC behind your name.

DO SOMETHING to celebrate passing the exam before you pass it!!!!

IV. Two days prior to the exam,
STOP studying and *relax!*

**Put your study material in a place where you can't get to it
(like UPS it to yourself using “UPS Ground”)!!**

Allow your energized brain to rest and your subconscious to perform.
Continue to visualize and verbalize your desire/intention to pass.

Chapter 1

Normal Human Growth & Development

NORMAL HUMAN GROWTH AND DEVELOPMENT

NCE - Chapter 1

Chapter Outline

INTRODUCTION

- I. Developmental Research
 - A. Systematic Observations
 - B. Designs for Research
 - C. Time Spans of Studies
- II. Life-Cycle, Life-Span Approach
- III. Nature vs. Nurture Controversy
 - Need to Know

PSYCHOANALYTIC THEORIES

- I. Sigmund Freud
 - A. Freud's Concept of the Unconscious
 - Conscious, Preconscious, Unconscious
 - B. Freud's System of Personality
 - Id, Ego, Superego
 - C. Freud as a Stage Theorist
 - Oral, Anal, Phallic, Latency, Genital
 - Biological energy, Cathexis, Fixation
 - Libido
 - D. Freud's Ego Defense Mechanisms
 - E. Other Freudian Concepts and Terms
- II. Carl Jung
 - A. Analytical psychology
 - B. Individuation, Personal Growth, Self-actualization
 - C. Logos vs. Eros Principle
 - D. Archetypes
 - E. Major Contributions
- III. Alfred Adler
 - A. Individual psychology; Becoming
 - B. Contributions and Significant Concepts
 - Birth Order
 - Early Recollections
 - Pampered childhood/negative effect
 - Taking risks
- IV. Harry Stack Sullivan
 - Observable interactions; Dynamism
 - A. Three modes of ego formation
 - B. Six Stages of Development

- V. Heinz Hartmann – Ego Development
- VI. Karen Horney
 - A. Basic Tenants
 - B. Basic Anxiety
 - C. Coping Strategies
 - D. The Tyranny of the Shoulds
 - E. Feminist-Based Criticism of Freud
- VII. Erik Erikson
 - A. Personality Constructs
 - B. Identity Crisis
 - C. Epigenetic
 - D. Maturation Theory
 - E. Psycho-Social Stages

Eight psycho-social stages of development; Flexible and growing personality
- VIII. Arthur Chickering
 - Seven vectors of development for college-aged students
- IX. Object Relations Theory
 - Mahler – Development of self in relations to others/objects

EXISTENTIAL / HUMANISTIC THEORIES

- I. Abraham Maslow
 - Hierarchy of needs; Self-actualization
- II. Person Centered – Carl Rogers
 - Self-theory of personality; Internal actualizing tendency

COGNITIVE THEORIES

- I. Jean Piaget
 - Four developmental stages
 - Sensorimotor
 - Pre-operational
 - Concrete Operational
 - Formal Operational
 - A. Children's Sense of Morality – heteronomous and autonomous morality
 - B. Mechanisms for growth
 - C. Additional Terms from Piaget's Work
- II. David Elkind
 - Validated Piaget's concept of conservation; Imaginary audience, personal fable
- III. Lawrence Kohlberg
 - The Heinz Story
 - Three Levels of Moral Development
 - Preconventional
 - Obedience and Punishment; Instrumental Relativist (Hedonism, Egotistic)
 - Conventional
 - Interpersonal concordance; Authority, Law, and Duty
 - Postconventional
 - Social contract or Democratically Accepted Law
 - Universal Ethical and Self-Conscious Principle

- IV. Carol Gilligan
 - Three Level, Two Transition Model of Female Moral Development
 - Orientation to Individual Survival
 - From Selfishness to Responsibility
 - Goodness as Sacrifice
 - From Goodness to Truth
 - Morality of Nonviolence
- V. Jane Loevinger
 - Ego development in seven stages and two transitions
- VI. William G. Perry
 - Cognitive-developmental sequences in college students:
 - Dualism, Multiplicity, Relativism, Commitment to Relativism
- VII. Robert Kegan
 - Life-span developmental model; Constant cognitive procedure
- VIII. Robert Havighurst
 - Birth to death developmental stages; Teachable moments

INFORMATION PROCESSING THEORIES

“Computer programming” model; Mental hardware and software
Case, Flavell, Siegler, Meltzoff, Sternberg

BEHAVIORAL THEORIES & SOCIAL LEARNING THEORIES (Includes Learning Theories)

Emphasis on environmental factors in the developmental process

- I. Classical Conditioning/Respondent Conditioning
 - Empiricism
 - A. Ivan Pavlov
 - Discovered associative learning process with dog experiments
 - Important concepts:
 - Acquisition
 - Conditioned Response
 - Conditioned Stimulus
 - Counter-Conditioning
 - Discrimination
 - Extinction
 - Stimulus Generalization
 - Spontaneous Recovery
 - Unconditioned Response
 - Unconditioned Stimulus
 - Contiguity
 - Contingency

- B. John Watson – Father of Behaviorism
Phobias; shaped behavior, Little Albert
 - C. Clark Hull
Theory of motivational processes (drive)
 - D. Joseph Wolpe
Anxiety reduction; Reciprocal inhibition; Systematic desensitization
- II. Operant Conditioning/Instrumental Learning
- A. Edward Thorndike
Law of effect
 - B. B. F. Skinner
Principle of reinforcement
Types of reinforcement:
Positive, Negative, Primary, Partial or intermittent, Punishment
Schedules of reinforcement:
Fixed-interval, Variable-interval, Fixed-ratio, Variable-ratio
Other terms
Successive approximation, Token economy
- III. Vicarious Conditioning also known as Social Learning Theory
Observational Learning
Cognitive Social Learning Theory, and
Linear-Interactionist Social-Cognitive
Theory
- A. Albert Bandura
Systems of Control: External stimuli, outcomes, symbolic
Modeling Processes: Attention, Retention, Reproduction, Motivation
Primary and secondary vicarious conditioning
 - B. George Kelly
Personal constructs; Constructive alternativism
 - C. Edwin R. Guthrie
One-Shot Learning, Practice
Habit reduction by fatigue, threshold, incompatible stimuli
- Question – Empiricism vs. Organicism

THE MEASURING OF PERSONALITY (Trait Theories)

- I. Henry Murray
Press; Thema; Basic and learned needs; TAT; EPPS
- II. Gordon Allport
Specific and general traits
- III. Raymond Cattell
Compiled list of surface traits; Sixteen source traits; 16PF

ETHOLOGICAL, BIOLOGICAL, AND PHYSICAL THEORIES

- I. H. F. Harlow
Bonding; Contact comfort
- II. Renee Spitz
Anaclitic depression, hospitalism
- III. Konrad Lorenz
Imprinting
- IV. John Bowlby
Adaptive function of attachment; Stages of prolonged separation
- V. Mary Ainsworth
Strange Situation; Four attachment behavior types; Four stages of attachment
- VI. Arnold Gesell
Maturation; Development quotient
- VII. Stella Thomas & Alexander Chess
Inherited temperament
- VIII. Gibson's Visual Cliff
Depth perception
- IX. Jerome Bruner
Influence of culture, evolution, integration, language
- X. William Sheldon
Constitutional personality theory; Body types; Temperaments
- XI. Additional Miscellaneous Data
Stranger anxiety; Separation anxiety, Ethology

AN OVERVIEW OF GROWTH AND DEVELOPMENT

- I. Physical Beginnings
Chromosomes, DNA, twins
- II. Factors Influencing Prenatal Development
 - A. Maternal Characteristics
Age, Nutrition, Emotional State and Stress
 - B. External Hazards in Prenatal Development
Maternal Diseases, Drugs, Environmental Hazards
- III. Generally Accepted Assumptions about Physical Growth
- IV. Critical Details of Central Nervous System Development

- V. General Issues of the Developmental Stages
 - A. Birth to 2 weeks old
 - B. Two weeks to two years old - Babyhood
 - C. Two years to six years – Early Childhood
Categories of Play
 - D. Six years to sexual maturity – Late Childhood
Gender differences: Physical, Cognitive, Socioemotional, Androgyny
Self-esteem and Parenting styles
 - E. Puberty to 18 - Adolescence
 - F. School and Education-Related Issues
 - G. Effects of Divorce and Remarriage on Parents and Children
- VI. Age-Related Patterns of Development
 - A. Birth to 4 Months
 - B. 5 to 8 Months
 - C. 9 to 12 Months
 - D. 12 to 18 Months
 - E. 18 to 24 Months
 - F. 24 to 36 Months
 - G. 36 to 48 Months
 - H. Four Year Olds
 - I. Five Year Olds
 - J. Six, Seven, and Eight Year Olds
 - K. Nine, Ten, and Eleven Year Olds

STAGES ADULT DEVELOPMENT

- I. Erik Erikson
 - Early Adulthood – Intimacy vs. isolation
 - Middle Adulthood – Generativity vs. stagnation
 - Late Adulthood – Integrity vs. despair
- II. George Vaillant’s Expansion of Erikson’s Stages
 - A. Career consolidation
 - B. Keeping the meaning vs. rigidity
- III. Roger Gould
 - Transformations from crisis; Seven stage model challenging myths
- IV. Daniel J. Levinson
 - Three adult transitions/seasons, Midlife crisis
- V. Gail Sheehy
 - Passages through six stages
- VI. Alice Rossi
 - Four parenting stages
- VII. Four-Stage Cycle of Sexual Arousal
 - Excitement Phase, Plateau Phase, Orgasm Phase, Resolution Phase
- VIII. Marriage

ISSUES RELATED TO THE AGING PROCESS

- I. Adjustment to Aging
Activity; Disengagement; Attachment
- II. Biology of Aging
Physical changes in all systems
- III. Realities of Aging
 - A. The Age Wave
 - B. The Myth about Decreasing Intelligence
 - C. The Myth about Decrease in Sexual Activity
 - D. Fear of death

ADDITIONAL MISCELLANEOUS INFORMATION

1. Ambidextrous
2. Anxiety
3. Apgar rating
4. Attitude
5. Cannon-Bard theory
6. Chaining
7. Cognitive Dissonance
8. Cohort effect
9. Communication
 - Verbal
 - Non-verbal – Kinetics; Proxemics
10. Critical Period
11. Curative Factors
12. Development
 - Learning
 - Maturation
13. Diagnostic and Statistical Manual of Mental Disorders (DSM)
14. Discrimination
15. Down's Syndrome
16. Drive
17. Echolalia
18. EEG
19. Egocentrism
20. Ekman
21. Emotions
22. Encoding
23. Epigenetic
24. Escape conditioning
25. Genotype
26. Hedonism
27. Heredity
28. Heritability
29. Holophrastic speech

30. Homeostasis
31. Identity Crisis
32. Insight
33. Interactionism
34. James-Lange Theory
35. Klinefelter syndrome
36. Lallation
37. Lamaze method
38. Latent learning
39. Learned Helplessness
40. Locus of Control
41. McClelland
42. Metaneeds
43. Midlife Crisis
44. Moral development
45. Motivation
46. Nosology
47. Ontogenesis
48. Opponent-Process Theory of Emotion
49. Phobia
50. Physiological psychology
51. PKU
52. Pre-adolescence
53. Programmed instruction
54. Psychodiagnosis
55. Psychometric
56. Psychopharmacology
57. Psychosis
58. Public Law 94-142
59. Rapid Eye Movement
60. RAS
61. Retrieval
62. Rites of Passage
63. Schachter Cognitive theory
64. Self-fulfilling Prophecy
65. Senile psychosis
66. Suicide
67. Split-brain Theory
68. Brain Lateralization Theory
69. Telegraphic Speech
70. Transfer Learning
71. Turner's Syndrome

NORMAL HUMAN GROWTH AND DEVELOPMENT

NCE - Chapter 1

INTRODUCTION

Our English word “develop” etymologically goes back to the Old French “desvoloper” meaning to “unwrap” or “unfold.” As man has sought from ancient times to bring understanding to the unfolding or development of a person, numerous hypotheses have been tested, countless theories put forth. Successful, happy living has come to be seen as a process of **growth**, the acquisition of new physical and psychological means.

Yet, as these new resources become available, the next challenge is already apparent. A new developmental task is at hand, which when successfully accomplished, sets the stage for the next level. Conversely, failure to achieve the task sets the stage for difficulty at the next level with the accompanying unhappiness and societal criticism. Thus, there is an ever-present **tension** between the person with his/her newly attained resources and the demands and expectations of society at large.

I. Developmental Research

Researchers have applied various methods in their quest for data that correctly represents the human developmental process. We briefly mention these research methods here simply to remind you that all theories of human development are derived from some method of observing behavior and then designing a way to draw appropriate conclusions from the data gathered.

For observation to be termed “systematic,” the who, what, when, where, how, and the form of recording the behavior must be predetermined.

A. Systematic observations include the following (Santrock, 1999; Kail & Cavanaugh, 1999):

1. **Laboratory Observations** – Observations take place in a controlled setting. Real world factors are eliminated.
2. **Naturalistic Observations** – Behavior is observed in its natural setting. No manipulation or control of the situation takes place.
3. **Interviews and questionnaires** – Skilled interviewing techniques and questions increase the reliability of the information given in survey methods.
4. **Case studies** – These dramatic, in-depth portrayals of people’s lives provide insight when the unique details of one’s life cannot be easily duplicated.
5. **Standardized tests** – Test scores are compared with the scores of a larger group of similar people.
6. **Life-history records** – A wide array of materials which may include written and oral reports from the subject, public records, etc.
7. **Physiological Research and Research with Animals** – The biological basis of behavior is explored and often explained.
8. **Multimeasure, Multisource, Multicontext** – Using multiple measures, sources, and contexts should provide a more comprehensive and valid assessment of development.

B. Two general designs for research are used by developmental researchers:

1. **Correlational Studies** – The researcher intends to describe the strength of the relation between two or more characteristics or events. Identical conditions are provided and variables are not manipulated.
2. **Experimental Studies** – Variables are manipulated to allow the researcher to determine the exact influence each variable causes.

C. The time span for a developmental research study is designed in one of these three ways:

1. **Cross-sectional** – People of different ages are observed and compared at one time.
2. **Longitudinal** – The same individuals are observed or tested over a period of time.
3. **Sequential** – The cross-sectional and longitudinal approaches are combined as the study begins with a cross-sectional study; the same subjects are then assessed again at a future date. Often, new subjects are added cross-sectionally at subsequent testings to control for changes that may have occurred in the original group.

II. Life-Cycle, Life-Span Approach

While theories of human growth and development have offered a variety of conceptual models for explaining the changes humans experience, the **life-cycle** approach (Santrock, 1999; Baltes, 1987) is currently the most widely used. The eight periods of **life-span** development are delineated in this order:

1. Prenatal
2. Infancy
3. Early childhood
4. Middle and late childhood
5. Adolescence
6. Early adulthood
7. Middle adulthood
8. Late adulthood

Current models increasingly separate Late Adulthood into the “young old” or “old age” (ages 65 to 74) and the “old old” or the “late old” (ages 75 and up) (Santrock, 1999).

III. Nature vs. Nurture Controversy

No textbook on human growth and development is complete without at least a paragraph on the nature vs. nurture argument regarding how and why development takes place.

Nature, of course, refers to the hereditary nature of development.

Nurture refers to the effect of the child’s environment on that development.

While some theorists have argued for one or the other’s influence, today’s theorists recognize that both factors powerfully impact development.

Need to Know

A well-rounded counselor needs a basic knowledge of all the currently accepted theories since no single theory gives a full explanation of human growth and development.

PSYCHOANALYTIC THEORIES

Basic assumptions of psychoanalytic theories:

- Biological forces drive development
- The individual strives to channel/control these drives
- Personality characteristics appear in childhood
- These characteristics are stable over time.

For our purposes, we will include the theories of both Freud and his **neops psychoanalytic** followers under this heading.

I. Sigmund Freud

Freud's admirers and critics alike agree that his work has had a greater impact on psychology, the psychotherapies, and the way we Westerners think about ourselves than any other person's theory of human growth.

As a practicing neurologist, Freud theorized from observing and treating his neurotic patients that humans are born with two basic instincts or urges: **eros**, the life instincts, and **thanatos**, the destructive or death instincts. From these come the mental or psychic energy for all mental processes and functions.

A. Freud's Concept of the Unconscious

Freud saw personality as having a conscious mind, a preconscious mind, and an unconscious mind.

1. **Conscious mind** – Known impulses, events, memories; present knowledge.
2. **Preconscious mind** – Easily recalled but not currently known memories and drives.
3. **Unconscious mind** – Emotions, thoughts, memories, drives etc. that are influencing behavior without current awareness; hidden or forgotten experiences.

Freud's concept of the **unconscious**, a radically new idea at the time, is thought by many to be one of his **greatest contributions** to psychological thought. Critics, however, emphasize that the unconscious cannot be verified scientifically.

Freud's notion of the unconscious, preconscious, and conscious mind is called a **topographical** concept. Just as a topographer is a map drawer, a Freudian analyst maps the mind as if it looked like an iceberg.

B. Freud's System of Personality

Freud believed that the two basic instincts of eros and thanatos plus some basic instincts compose the undifferentiated personality of a newborn. This personality is divided into three processes or **systems** (Corey, 1996).

1. The **id**
The **id** is present at birth and represents a biological, instinctual component that cannot bear tension. The id functions under the pleasure principle and, therefore, demands immediate gratification, the avoidance or diminishing of pain, and the securing of pleasure. The id is not rational or logical and has no concept of time. The id is part of the unconscious mind.
2. The **ego**
The **ego** develops as the psychological component that wields power over the id. The ego functions under the reality principle and, therefore, logically and realistically plans appropriate ways to fulfill needs. The ego is pressed by the id to give in to pleasure and gratification in spite of the consequences. The ego operates primarily in the conscious and preconscious minds.
3. The **superego**
The **superego** represents the social component, made up of the conscience and ego ideals. It is from the superego that a person pursues perfection. Guilty feelings result from a violation of the standards and morals set by the superego.

C. Freud as a Stage Theorist

1. As a stage theorist, Freud postulated that the human personality is determined in the most critical years of personal development - the **first five years** of life.
2. Freud saw maturity as the living out of the results of the pre-genital (oral, anal, and phallic) and genital stages.
3. Freud viewed **biological energy** as the source of all basic drives as people progress through the stages of life. Three sources of energy are
 - a. **Sexuality** (Originally referring to sexual energy, the concept of **libido** was later broadened to encompass the energy of all the life instincts.)
 - b. **The drives of hunger and pain**
 - c. **Aggression**
4. **Cathexis** is the process by which sources of energy are tied to thoughts, actions, objects, or people.
5. **Fixation** is the resistance of a person to move to the next stage because the cathexis is too intense. In other words, if a person experiences either too much pain (trauma) or too much pleasure at any given stage, he/she may resist letting go of that stage. Cognitive and physical development occurs, but emotional development is "stuck." Fixation during a stage leads to certain problems as adults.

Each of Freud's stages is emblematic of certain developmental issues and is named for the corresponding physical (bodily) source of pleasure (psychosexual stage):

Stage	Characteristic Behavior
Oral: 0 - 2 years	Pleasure is derived from nursing and sucking. Infants will put everything into their mouths.
Anal: 2 - 3 years	The first experience of "imposed control" is found in the form of toilet training. Gratification is derived from withholding or expelling feces.
Phallic: 3 - 6 years	Pleasure is derived from fondling genitals. Children observe the differences between males and females and direct their awakening sexual impulses toward the parent of the opposite sex: Oedipus Complex – boy desires sexual relations with his mother. Electra Complex – girl desires sexual relations with her father. In order to become an ally of: his father, the boy will adopt traditional male roles. her mother, the girl will adopt traditional female roles. The Oedipus Complex is Freud's most controversial concept. Freud theorized that the identification of the child with the same-sex parent leads to internalization of authoritarian/parental values which leads to the emergence of the super-ego or conscious.
Latency: 6 - puberty	The child becomes less concerned with his/her body and turns his/her attention to the skills needed for coping with the environment. This is the only stage not primarily psychosexual in nature.
Genital: puberty	The adolescent begins to turn his/her interests towards others and to love in a more mature way.

D. Freud's Ego Defense Mechanisms

1. **Anxiety** is the result of conflict among the id, the ego, and the superego. Ego defense mechanisms are employed as unconscious coping mechanisms when the superego cannot control anxiety by rational and direct methods (Corey, 1986). Ego defense mechanisms reduce anxiety by denying or distorting reality. Freudians believe that **repression** is the most important of the ego defense mechanisms.
2. Sixteen Ego Defense Mechanisms are given on the following page.

EGO DEFENSE MECHANISMS

1. **Displacement** – means displacing or directing emotion onto a person/object other than the one that originally aroused the emotion.

Example: A meek employee, who is continually ridiculed by her boss, builds up tremendous resentment but verbally attacks family members instead of her boss, who might fire her.

2. **Rationalization** – is justifying behavior to oneself and to others with well thought-out and socially acceptable but fictitious reasons for certain behaviors. This is not just lying; it's a matter of habit and intensity.

Example: A high school student explains away her failing of an algebra exam by saying, "I really don't see why I have to take this course. I don't need it to graduate and that teacher just sits there and doesn't explain anything."

3. **Compensation** – means attempting to overcome the anxiety associated with a feeling of inferiority in one area by concentrating on another where the person can excel. This may be healthy and constructive; it may be avoidance.

Example: A woman who cannot bear children becoming overly attached to pets.

4. **Projection** – entails attributing to another person feelings and ideas that are unacceptable so the other person seems to have these feelings and ideas.

Example: Feeling like a coward in handling a situation but blaming the outcome on the cowardice of the other person.

5. **Reaction Formation** – involves exaggerating and openly displaying a trait that is the opposite of the tendencies that we do not want to recognize (traits that have been repressed).

Example: People who are zealots about smut but really have hidden desires.

6. **Denial** – means failing or refusing to acknowledge or to recognize and deal with reality because of strong inner needs.

Example: Ignoring the symptoms of a heart attack; wearing copper bracelets.

7. **Repression** – is an unconscious process of blocking urges, forbidden or dangerous desires, or traumatic experiences from consciousness. This is the most basic defense mechanism according to Freud. (Suppression is a conscious process.)

Example: A police officer who witnesses the violent death of a fellow officer may press the incident out of consciousness because it symbolizes his own mortality.

8. **Identification** – is the attempt to overcome feelings of inferiority by taking on the characteristics of someone important to oneself.

Example: A student who takes on characteristics/attributes of his/her mother, father, favorite teacher, or coach.

9. **Substitution** – involves achieving alternate goals and gratifications in order to mask feelings of frustration and anxiety.
Example: Young girls who miss their father shacking up with an older man.
10. **Fantasy** – involves retreating in one's mind to a comfortable (maybe ideal) setting. While one of the most useful defense mechanisms, it can become addictive and substitute for honest effort.
11. **Regression** – consists of reverting to a pattern of feeling, thinking or behavior appropriate to an earlier stage of development.
Example: A competent and capable adult acting very childish when sick in an attempt to have those around them provide greater care.
12. **Sublimation** – is the redirecting of unacceptable impulses into socially and culturally acceptable channels.
Example: Ones need for approval leading to an interest in theatre productions.
13. **Introjection** – is the taking in, absorbing or incorporating into oneself the standards and values of another person.
Example: The abused child who becomes an abusive parent.
14. **Undoing** – occurs when a person acts inappropriately thus producing anxiety; then the person acts in an opposite way so as to reverse or negate the original behavior thus extinguishing the original anxiety.
Example: A child yells at the dinner table and then offers to help with the dishes.
15. **Emotional Insulation** – is protecting oneself from hurt by withdrawing into passivity.
Example: "Looking for a new job will bring rejection so I'll just go with the flow and see what happens."
16. **Isolation** – is separating the emotion from an experience so as to deal dispassionately with an otherwise emotionally overwhelming topic.
Example: Making funeral arrangements instead of grieving.

E. Other Freudian Concepts and Terms

1. Incest

Freud published *Totem and Taboo* summarizing his theory that family groups in other cultures **dread incest**, meaning that the dread of incest is inborn and not just a product of societal expectations.

2. Wish Fulfillment

- Freud believed that a **dream** can be a **wish fulfillment**. These wishes or desires can either be conscious or unconscious.
- A **slip-of-the-tongue** can also signify such a wish or desire.

3. Freud's theory is a Maturation Theory

- Freud's developmental theory could be classified as a **maturation theory** (as is Erikson's) because Freud believed that the developmental order or the unfolding of behavior is programmed by heredity.
- Certain stimuli must be present in the environment, however, for the next behavior to emerge.
- Additionally, a necessary predetermined level of neural development must be present for the next behavior to emerge.

II. Carl Jung

A. Analytical Psychology

Jung's theory, **analytical psychology**, grew out of Jung's disagreement with Freud that neuroses originated in the libido (sexual origin). Jung instead emphasized a general psychic energy (Hunt, 1993).

B. Individuation • Personal Growth • Self-actualization

- Also, Jung believed that individuals by instinct are driven toward **individuation**, that agreement or harmony between the conscious and unconscious parts of their personality.
- This wholeness or personal growth is realized as the individual becomes more and more aware of his/her unconscious side.
- This progress toward self-actualization can be a life-long process.

C. Logos vs. Eros Principle

Jung said that: men operate on logic or the **logos principle**;

women operate on intuition or the **eros principle**.

D. Archetypes

Jung's review of literature led him to believe that certain archetypes have appeared in religious writings, dreams, myths, and fables since the dawn of recorded history. These **archetypes** are the common, collective unconscious which is passed on from generation to generation.

Some common archetypes are:

- **Anima** – the female characteristics of the personality
- **Animus** – the male characteristics of the personality
- **Shadow** – the unconscious opposite of a person's conscious expression
- **The Persona** – the mask worn or the role presented to hide one's true self

E. Major Contributions to the Field of Psychology

- Jung is credited with the word-association technique and the introversion-extroversion concept.
- **The Myers-Briggs Type Indicator**, a leading personality inventory using bipolar scales, is based on Jung's work.

III. Alfred Adler

A. Individual Psychology

Adler's (1963) holistic view of development, **individual psychology**, asserts that what an individual is born with or into (heredity and environment) is not the determining factor in one's development. Rather, the endeavoring to reach individual goals determines an individual's lifestyle and behavior. Therefore, one is always **becoming**, trying to achieve one's self-ideal. Feelings of **inferiority** come from one's self not matching the self-ideal. He accepted being called "father of the inferiority complex."

Note: The term **organ inferiority** is associated with Adler because of his 1907 publication *Study of Organ Inferiority and Its Psychological Compensation* in which he argued for broadening the biological basis for neurosis from gender to the entire organism.

B. Contributions and Significant Concepts

1. **Birth order makes a difference.** The birth of each child impacts the family system thereby influencing the personality development of each child; in effect, each child is born into a different family environment. Following is a brief listing of birth order characteristics (Corey, 2001). This listing of characteristics is not meant to be exhaustive.
 - Oldest** – Usually high achievers, dependable, hard working, "parent pleasing," conforming, well-behaved, may have an underlying insecurity from being displaced by the second child.
 - Second** – Usually outgoing, less constrained by rules, seems to be in a race to surpass the older sibling, and often excels at what the first born does not.
 - Middle** – Become concerned with perceived unfairness as he or she feels squeezed out, can become a problem child, thrive in family politics and negotiations, and may become manipulative.
 - Youngest** – Usually adept at pleasing or entertaining the family, often high achievers, tend to go their own way into areas of development no other family member has even considered, run the risk of being spoiled.
 - Only** – Usually a high achiever like an oldest child, deals well with adults, may be slow in developing social skills, may be pampered or spoiled. These characteristics also apply to children born seven or more years apart from siblings.
2. **Early recollections are a key to understanding an individual's style of life.** Adler believed that by age 5 a child's interpretations of life's events are set since the child has been taught by that time to perceive things through the subjective evaluations presented in his/her interactions with their family members. Adler called the perceptions that guide children's behavior **fictions**. Mistakes such as overgeneralizing can be caused by a child's fiction that everything is the same or alike.
3. **Being pampered as a child or being neglected as a child has a negative effect as a person grows older.**
4. Adler believed that life is a courageous endeavor that **requires a willingness to take risks without knowing the outcome**. Well-adjusted individuals participate in **interdependent, cooperative** relationships.

IV. Harry Stack Sullivan

Sullivan (1953) was the most influential theorist to discuss the importance of friendships. Sullivan's theory, known as the psychiatry of interpersonal relations, emphasizes **observable interactions** among people. He stressed the **dynamism** or power of self, which Sullivan holds as being affected by what the outside world expects. This power motive is the path to overcoming a sense of helplessness. According to the events in an individual's life, contradictory **personifications**, one's comprehension of self (me) and other (not me), may surface at the same time. Then the individual must grapple with balancing the good-me and the bad-me (Axelson, 1993).

A. A person experiences interpersonal relationships and thus experiences ego formation through these three modes of experience:

1. **Protaxic** – Infancy; the infant has no concept of time and place.
2. **Parataxic** – Early childhood; the child accepts what is without questioning or evaluating and then reacts on an unrealistic basis.
3. **Syntaxic** – Later childhood; the child is able to evaluate his/her own thoughts and feelings against those of others and learns about relationship patterns in society.

B. Sullivan's Six Stages of Development:

1. **Infancy** – Being nursed provides the initial social experience (“good mother” feeds; “bad mother” withholds).
2. **Childhood** – Societies' expectations of behavior are learned; language is acquired.
3. **Juvenile** – Entering school moves the child out of the family; individual goals begin to develop.
4. **Preadolescence** – Close same-sex friendships develop; social rules with reciprocal concepts develop.
5. **Early Adolescence** – Heterosexual interests are sparked by puberty.
6. **Late Adolescence** – Social awareness develops; establishing a family and contributing to the community become the task at hand.

V. Heinz Hartmann

Hartmann's **logical and abstract mode of thought** set the stage for the development of **ego psychology** as he theorized that ego was present at birth instead of evolving from the id. Hartmann thought the ego had its own energy and exerted control of its own over processes such as perception, reasoning, and memory. Ego functioning rather than id impulses became the theoretical focus.

Hartmann suggested that instinctual drives alone could not guarantee survival, but that an innate ego apparatus is present for an infant to adapt to the **average expectable environment**. Of course, for Hartmann the average expectable environment was that of Western civilization in the late nineteenth and early twentieth centuries.

Karen Horney and Erik Erikson both agreed with the concept of an innate ego but rejected Hartmann's concept of adaptation to an average expectable environment (Corsini, 1984).

VI. Karen Horney

A. Basic Tenants

- Horney believed as Freud did in the importance of powerful unconscious intrapsychic conflicts. Yet, she dismissed the construct of libido and the assumption that people are motivated by an inborn sense of self-destruction.
- Like Adler, she emphasized the social, rather than the biological, rudiments of personality development.
- Horney espoused an innate capacity and desire toward positive growth.

B. “Basic Anxiety”

- Neurosis is the outworking of what Horney called “**basic anxiety**.”
- Alleviating the basic anxiety stemming from the apprehension and insecurity caused by being raised by neurotic parents becomes the major focus.
- Manipulating people and events to one’s own advantage with the misguided belief that this brings the sought after self-protection overrides the healthy quest for self-realization.

C. Coping Strategies

Horney suggests that when the basic anxiety is not removed, maladaptive coping strategies will be employed:

- becoming hostile and vengeful
- becoming overly submissive
- developing an unrealistic inflated self image
- trying to threaten or bribe others into liking him or her
- wallowing in self-pity to gain sympathy
- seeking to dominate or exploit others
- becoming inappropriately competitive
- belittling oneself

These coping strategies were viewed by Horney as neurotic solutions to an insatiable need that comes from not having sufficient trust, love, and security in the home during upbringing.

D. The “Tyranny of the Shoulds”

- Horney also wrote about “the tyranny of the shoulds” meaning that the inner demand to aim toward self-realization is relentless.
- Neurotic individuals may conclude that they should have achieved perfection in areas of development and therefore become dominated by the “shoulds.”
- The healthy person, on the other hand, is able to recognize his or her needs and desires and to move toward enjoyable, rewarding goals.

E. Feminist-Based Criticism of Freud

- Horney is also credited with the first feminist-based criticism of Freud’s theory.
- She developed a model of women with positive feminine qualities and self-evaluation in reaction to the male-dominated society and culture of Freud’s day. (Santrock, 1999)

VII. Erik Erikson

A. Personality Constructs

- Erikson accepted Freud's three-part division of the personality, yet he felt that the personality was flexible and capable of growth and change throughout the adult years; a person is not a prisoner of his/her past.
- Erikson perceived the ego as an autonomous component, able to remain independent of the sexual and aggressive drives while still expressing creativity.
- **Ego identity** is the balance of what "one feels one is and what others take one to be" (Erikson, 1963). The ego is not content to merely absorb and incorporate (assimilate) parental qualities; the ego works toward becoming an autonomous, unique self.

B. Identity Crisis

- Erikson coined the term "**identity crisis**," meaning that an adolescent is not able to integrate all of his or her previous roles into a single self-concept.
- Some of these roles are of an experimental nature as adolescents attempt to find out who they really are.
- Conformity with peers is at issue.

C. Epigenetic

- Erikson's theory is based on the **epigenetic principle**, meaning that each strength has its own period of particular importance.
- As the individual progresses through the development of these strengths, it is up to the individual to make something of his or her life.
- Ego identity requires more than simply mirroring or reflecting the values of someone he or she admires.

D. Maturation Theory

- Erikson's developmental theory could be classified as a **maturation theory** (as is Freud's) because Erikson believed that the developmental order or unfolding of behavior is programmed by heredity.
- Certain stimuli must be present in the environment, however, for the next behavior to emerge.
- Additionally, a necessary predetermined level of neural development must be present for the next behavior to emerge.

E. Psycho-Social Stages

- Erikson's (1950; 1963) developmental theory includes eight **psycho-social stages** which unfold with continuity over the life span as the individual endeavors to attain a mature sense of identity.
- Erikson believed that psychosexual growth took place simultaneously with the psycho-social stages.
- The individual must face and resolve a particular task, crisis, or conflict at each level. The psycho-social crisis results in a turning point.
- **Total success or failure is not necessary; an individual will have a tendency toward one alternative or the other.**
- Mastering all the stages will give a person the sense that his or her life has been worthwhile.

Erikson formulated the following eight stages of development:

Developmental Stage	Psycho-social Crisis
1. Early infancy (Birth - 1 year)	Basic trust vs. mistrust
2. Later infancy (1 - 2 years)	Autonomy vs. shame & doubt
3. Early childhood (3 - 5 years)	Initiative vs. guilt
4. Middle childhood (6 - 11 years)	Industry vs. inferiority
5. Adolescence (12 - 20 years)	Identity vs. role confusion
6. Early adulthood (20 - 35 years)	Intimacy vs. isolation Sharing one's life with others vs. I'm the only one I can depend on
7. Middle adulthood (35 - 65 years)	Generativity vs. stagnation The productive ability to create a career, family, leisure time, etc. vs. self-absorption
8. Late adulthood (65+ years)	Integrity vs. despair Life has been worthwhile vs. life's precious opportunities have been wasted.

VIII. Arthur Chickering

- Chickering (1987) observed **traditional-aged college students** and concluded that they progressed through seven distinct dimensions in what Erikson called the identity stage.
- He preferred to call these dimensions of development **vectors** thereby conveying the allowance of **development in several different vectors concurrently**.
- These vectors describe the primary concerns of the student, the confronting task, and the focus or preoccupation of the student.
- Stimulation rather than physiological maturation plays an important role.
- As such, development is not identical; students are developmentally diverse.
- Chickering's **seven vectors** are:
 1. **Achieving competency**
 2. **Managing emotions**
 3. **Becoming autonomous**
 4. **Establishing identity**
 5. **Freeing interpersonal relationships**
 6. **Clarifying purpose**
 7. **Developing integrity**

IX. Object Relations Theory

The term **object** was used by Freud to mean that which satisfies a need or that which is the target of one's feelings or drives. It is used synonymously with the term **other** to mean an important person to whom one becomes attached.

Object relations theory pertains to the **developmental stages of the self in relationship to others/objects**, particularly at young ages.

Once self/other patterns are formed, it is assumed that the individual will seek to establish relationships that match those earlier patterns. For example, it is assumed that people who are overly dependent or overly attached may be repeating patterns formed with their mothers when they were toddlers (Hedges, 1983).

Children who do not form appropriate connections develop splits with the family.

MARGARET MAHLER, a central influence on contemporary object relations theory, suggests that the self develops through **four broad stages** (Corey, 2001):

1. **Normal infantile autism** (first 3 to 4 weeks)
There is no whole self and no whole objects. The infant perceives individual parts such as face, hands, mouth, and breasts.
2. **Normal Symbiosis** (3 to 8 months)
The infant has a pronounced dependency on the mother or primary caregiver and seems to expect a high level of attunement with this person.
3. **Separation-Individuation** (begins by the 4th or 5th month, overlapping the second phase)
The child moves through several sub-phases away from the symbiotic forms of relating to a place of separation from significant others while still turning to them for comfort and a sense of confirmation.
4. **Constancy of self and object** (typically pronounced by 36th month)
Others are more fully seen as separate from self. Relating is possible without fear of losing their individuality. Ideally, a firm foundation is laid for entering the later psychosexual and psychosocial stages of development.

Borderline and narcissistic disorders appear to be rooted in traumas and developmental disturbances that take place in the separation/individuation phase.

Otto Kernberg,

Heinz Kohut, and

J. F. Masterson are among the most significant object relations theorists shedding light on these disorders.

Framo, a family therapist, uses object relations theory in treating families.

EXISTENTIAL / HUMANISTIC THEORIES

Basic assumptions of existential-humanistic theories:

- Perception of self is key.
- Trust in person's ability to make constructive, conscious choices.
- Humans are inherently good.
- Respect for the client's subjective experience.

I. Abraham Maslow

Maslow (1962) founded his theory of personality upon a hierarchy of needs comprised of

- **lower-order needs (physiological necessities and safety)**
- **higher-order needs, sometimes called metaneeds, (belongingness and love, self-esteem and, finally, self-actualization)**

Assuming the presence of a supportive environment, Maslow contended that it is human nature to strive toward self-actualization, which is characterized by:

- efforts to create and learn
- acceptance of and a democratic attitude toward others
- a sense of autonomy

While many developmental theories have been formulated from work with the mentally ill, Maslow insisted on observing and assessing only those who had escaped what he called “the psychology of the average.” He felt that studying the “pathology of the average” will give “sick” theory. Not surprisingly, his self-actualized subjects were over 60. He also saw analytical psychology and behavior modification as dehumanizing.

Maslow used the term “**third force**” psychology since he considered it to be in opposition to psychoanalysis and behaviorism.

II. Carl Rogers

Rogers (1961) expounded a self-theory of personality. He believed that problems occur when one's real self (self-concept) and one's ideal self are not the same; there's a discrepancy between the two. The actualizing tendency is the motivating force that leads individuals to do away with the discrepancies and thereby reach their highest potential.

Rogers also believed that behavior is internally, not externally, driven.

COGNITIVE THEORIES

Basic assumptions of cognitive theories:

1. Development is strongly biological.
2. Children are to actively explore their environment.
3. The response to the exploration will depend on their individual understanding.
4. Personality development is greatly tied to cognitive abilities.

I. Jean Piaget

- According to Piaget (1954), the successful progression of an individual through four developmental stages results in mature, formal operational thinking (see next chart). Most importantly, this thinking is abstract.
- At each level, the child strives to make sense of what he experiences by grasping the oddities (what is odd to him/her) and then integrating his/her ideas into a unified **schema** of thought.

Piaget's research was informal and innovative as he devised games and interviews, many with his own children (which has been a source of criticism by some other theorists).

Piaget's contributions to the understanding of cognitive development fall into **four observations**:

1. Individuals exhibit **irregular rates of development**. Each stage evolves from a **readiness phase** in which prerequisites for the next stage are attained to an **attainment phase** in which the individual employs characteristics required for the next functioning stage.
2. The development within each stage is a **gradual, broadening** of the capacity **toward** usage of the **highest elements** within that stage of operations.
3. A "**state of mind**" involving an element of self-consciousness develops when new or next-stage tasks are attempted.
4. With progress through each higher order stage comes "**decentering**" as the individual's focus moves from self to the outer world.

Piaget's term "**operation**" denotes a particular set of internalized actions or a routine that is reversible – a logical opposite operation exists for each operation. These operations permit the child to perform mental functions that previously were performed physically; intellectual growth is realized as more and more of these "operations" are accomplished.

The following is a summary of Piaget's (1954) four stages:

STAGE	CHARACTERISTICS
Sensorimotor (0 – 2)	• Sensorimotor intelligence is showcased (reflexes). • A child's actions are indicative of the child's intelligence. Infants grow to recognize themselves (self) as able to effect action. • The child begins to act intentionally, e.g. jiggling a toy to make noise. • Object permanence (the realization that objects exist even when they are no longer perceived by the senses) develops. • Piaget said that the essence of this stage is portrayed by the term "practical intelligence."
Pre-operational (2 – 6)	• Words, images, and drawings are used by children to represent their world. • Thought patterns remain egocentric as the child cannot distinguish between his/her perspective and that of someone else. • Objects are sorted or classified by just one feature (centration), e.g. all green toys are grouped together regardless of size or type. • A key development of this stage is the realization that an object can be used for more than one purpose, not just for its originally intended purpose/use, e.g. a frisbee becomes a steering wheel of an imaginary car. • In Piaget's terminology, all symbolic schemata are acquired in this stage laying the foundation for language acquisition and symbolism usage in play.
Concrete Operational (6 – 12)	• A logical element enters a child's thinking about events and objects. • Conservation of numbers (about age 7) and of weight (about age 9) marks this stage. • More features can be accommodated during classification. • Series and sub-sets are used. • The child operates in the here and now yet is able to mentally visualize and make mental representations, e.g. being able to tell how to get from home to the gas station.
Formal Operational (12 years+)	• The child is able to think abstractly and logically and can apply systematic deductive reasoning to hypothetical and contrary-to-fact problems. • Multiple hypotheses regarding a situation may be entertained. • A lack of success in algebra, geometry, and physics indicate that this stage of operations may not have been reached. • The future, ideological problems, and hypothetical situations become the child's concerns as he/she becomes preoccupied with thinking. • Characteristic patterns of this stage include problem solving, plan making, validating beliefs, and differentiating one's self-awareness based on his/her roles in life. • The child is ready for adulthood and will not experience childlike feelings of helplessness. • Piaget felt that many people never attain these operations.

A. Children's Sense of Morality

Piaget's observation of children playing games (how they dealt with the rules) and their answers to questions about ethical rules (lies, theft, etc.) led him to conclude that children think in two distinct ways about moral issues, depending on their developmental maturity:

1. **Heteronomous morality** is the first stage and occurs from approximately ages 4 to 7. Rules and justice are viewed as absolutes; they cannot be changed by people.
2. **Autonomous morality** is the second stage and begins at about age 10. Children begin to realize that rules are created by people and that intentions and consequences can be taken into consideration.

Children between 7 and 10 are thought to be in transition and will exhibit some features of both stages.

B. Mechanisms for Growth

Three major mechanisms that allow a child to **adapt** and, therefore, move from one stage to the next are assimilation, accommodation, and equilibration.

1. **Assimilation** is the incorporation of old ideas or old habits with new objects thus providing a new event (taking in new information, noticing, comprehending).
2. **Accommodation** is the adjusting to a new object or new information; the changing of one's conceptions to fit the new object (revising concepts based on new information).
3. **Equilibration** is the devising/forming of new theories in order to realize balance between assimilation and accommodation.

Children are continually constructing "**schemas**" which represent the children's conceptualization of their knowledge. These cognitive structures are modified as the child's knowledge is expanded. This "**organization**" leads to "**adaptation**." Assimilation and accommodation are required over and over through the stages.

Disequilibrium occurs when the child's current schemas cannot process new information. The child changes the schemas and equilibration or equilibrium is reestablished.

Mental growth comes as an individual deals with the inconsistencies (the tension) between his/her assimilation and accommodation; thus, it is not just the acquisition of more information that brings progression to the next stage. The advancement results from the new, distinctively different way of understanding.

While Piaget considered himself to be a **genetic epistemologist** (epistemology is the study of how we know what we know), his theory naturally applied to the education process. He believed that until the formal operational stage is reached, learning is most effective through experimentation, experiential, interactive methods, not lectures.

C. Additional Terms to know from Piaget's work

1. **Egocentrism** – the quality of not being able to view an object from another's vantage point.
2. **Centration** – the quality of focusing on a key feature rather than on the whole object (looking at someone's eyeglasses instead of the whole face).
3. **Conservation** – achieved during the concrete operational stage; the understanding that the weight, mass, and volume remain the same in spite of the shape (empty a tall, thin bottle of water into a short, wide bottle).
4. **Reversibility** – achieved during the concrete operational stage; the understanding that an object can return to its former shape, an action can be undone.
5. **Object permanency** is sometimes called **object constancy**.
6. **Representational thought** is a necessary component of object permanency.
7. The concept of **time** refers to the understanding that events take place one after the other.
8. **Causality** refers to the understanding that the child can cause something to happen.
9. **Deductive thinking** – drawing appropriate conclusions from facts.

II. David Elkind

Being a **student of both Piaget and dynamic psychology**, Elkind is probably best known for his attempt **to extend, to integrate, and to apply these psychologies to educational and to social problems of children and youth.**

Elkind describes himself as an **applied developmental psychologist** seeking to apply research and theory to practical problems, while using practical experience to guide research and to expand theory.

He has contended that child and adolescent psychology are relatively new fields that would benefit from careful observation, categorization, and analysis before experimentation is implemented (Corsini, 1984).

Elkind's statistical research has been valuable in that it has **validated** many of Piaget's concepts such as what Piaget called **conservation**.

Elkind agrees that **mass is the first and most easily understood concept; weight is second, and volume is third.**

Human development texts often refer to two of Elkind's concepts:

1. **Imaginary audience** – Part of the adolescent's egocentrism; the belief that others are as preoccupied with the adolescent as the adolescent is with himself or herself.
2. **Personal fable** – Part of the adolescent's egocentrism; adolescent's belief that his/her individual experiences are unique, that no one has ever felt or thought like he/she does.

III. Lawrence Kohlberg

Kohlberg (1984) expanded upon Piaget's model to explain and to account for such social phenomena as gender identity, sexual typing, and emotional ability.

He emphasized the relationship between cognitive and intellectual development.

Over 60% of Kohlberg's middle-class urban male subjects had not attained the postconventional level (Rosenthal, 1993). Kohlberg believed that many people never reach the postconventional or self-accepted morality level in which the common good of society is a central theme. Socrates, Gandhi, and Martin Luther King, Jr. are sometimes given as examples of people who have reached that highest level.

Additionally, attaining the level of development and then choosing to behave accordingly are two different things (Dacey & Travers, 1994).

Kohlberg asked his subjects to judge hypothetical situations/moral dilemmas and then to explain the reasoning for their behaviors or actions. One such hypothetical dilemma is presented in the **Heinz Story**:

A woman in Europe was dying of cancer. Only one drug (a form of radium) could save her. It was discovered by a local druggist. The druggist was charging \$2,000, which was ten times his cost to make the drug. The woman's husband, Heinz, could not raise the money and even if he borrowed from his friends, he could only come up with approximately half the sum. He asked the druggist to reduce the price or let him pay the bill later since his wife was dying but the druggist said, "No." The husband was thus desperate and broke into the store to steal the drug. Should the husband have done that? Why?

The reason for the decision, not the decision itself, allowed Kohlberg to assess the person's stage of moral development. Kohlberg felt that his stages and levels apply to all cultures, but research has contradicted that assumption.

Kohlberg is perhaps best known for his theory of the development of a person's stages of **justice** or **moral reasoning**. His model has three levels with two stages each (see next page).

Kohlberg's Levels and Stages of Moral Development

(The ages indicated are merely intended to give an idea of when that level might be attained.)

LEVEL 1: Preconventional Morality (around ages 4 to 10)

Self-guided moral behavior with accompanying consequences (premoral).

Stage 1: Obedience and Punishment Orientation

A punishment or consequence is more important than societal expectations or the law.

Stage 2: Instrumental Relativist Orientation (sometimes called **Naïve Hedonism** or **Egotistic**)

An individual's social judgments and interactions are based out of self-needs (self-centeredness).

LEVEL 2: Conventional Morality (around ages 10 to 13)

An individual's social judgments and interactions are based out of a desire to preserve one's place in society, to meet the expectations of the family and society; often termed "morality of conventional rules and conformity."

Stage 3: Interpersonal Concordance Orientation

Behavior is chosen to please and gain approval. The term "good girl/good boy" characterizes this level (one follows the rules; does what he/she is supposed to).

Stage 4: Authority, Law, and Duty Orientation

Rules and laws are viewed as promoting the common good and maintaining social order; therefore, there is a duty to obey them.

LEVEL 3: Postconventional Morality (around ages 13 and older)

(sometimes called **Morality of Self-Accepted Principles** or **Personal Integrity**)

Moral behavior is guided by a self-accepted/self-imposed commitment to moral principles.

Stage 5: Social Contract or Democratically Accepted Law Orientation

Society as a whole examines moral principles and then agrees upon or changes them by consensus.

Stage 6: Universal Ethical and Self-Conscious Principles Orientation

An individual's social judgments and interactions are based out of universal principles (morality, ethics, legality) instead of the rules of society.

IV. Carol Gilligan

Carol Gilligan (1982, 1985) criticized Kohlberg's model of moral development as being too male oriented. She suggested that **care and responsibility in interpersonal relationships must be considered** in moral development models, especially with females.

Based on her research, Gilligan suggested:

- **Male development** is based on **separation and individuation**.
- Males use principles of individual rights and justice to form moral judgments.
- **Female development** focuses on **relationships/connections**.
- Females use principles of self-responsibility and responsibility for others (care-giving).

Gilligan viewed female moral development as a progression through **three levels** with an obvious transitional bridge from level to level.

LEVEL 1: ORIENTATION TO INDIVIDUAL SURVIVAL

Children are preoccupied with their own needs. Only when needs are in conflict do moral considerations surface.

First Transition: From selfishness to responsibility

Relationships with others define the self.

LEVEL 2: GOODNESS AS SELF-SACRIFICE

- Social norms define moral judgments.
- Girls learn that women are supposed to be predominantly caretakers.
- Self-sacrifice is a virtue.
- Personal responsibility is emphasized.

Second Transition: From goodness to truth

- Fulfilling the needs of both self and others is the challenge.
- The intention, motive, and consequence of an action are important.
- Personal responsibility is increasingly emphasized.

LEVEL 3: THE MORALITY OF NONVIOLENCE

- Claiming and using principles of not hurting self or others form the basis for resolving moral conflicts between selfishness and responsibility.
- Choices are made with personal responsibility.
- The caregiver role is seen as a self-chosen universal moral obligation.

Note: Gilligan agreed with Kohlberg that moral reasoning becomes progressively sophisticated via progression through distinct stages. Whether her claim that care instead of justice is at the base of female moral judgment is still being researched.

V. Jane Loevinger

Loevinger's (1976) theory of **ego** development proposes seven stages and two transitions. As with both Piaget and Kohlberg, Loevinger sees each stage as having special aspects of character development, interpersonal style, conscious pre-occupations, and cognitive style.

Loevinger's **seven-stage** ego development sequence:

1. **Presocial/Symbiotic Stage** – Initially, the infant cannot distinguish between self and nonself. The environment is not seen as animate and inanimate. As the infant enters the symbiotic substage, the environment and the mother are seen as separate entities, but the infant does not distinguish himself or herself from the mother.
2. **Impulsive Stage** – The child distinguishes self from the mother. The child is impulsive, exploitive, and dependent. Sexual and aggressive drives are predominant.
3. **Opportunistic Stage** – Obedience to rules, morality, and motivation are based in expediency and immediate advantage/gratification. The child is manipulative and focused on controlling others.
4. **Conformist Stage** – Rules are partially internalized. Transgression results in shame. Trust develops. The child is preoccupied with social acceptance, appearance, and material possessions.

Self-aware Level Transition from Conformist to Conscientious Stage – The individual has reached a stable position in his or her mature life. Alternatives and Exceptions are perceived. Adjustment is the task at hand.

5. **Conscientious Stage** – Moral imperatives control morality which is now internalized. Transgression results in guilt. Interpersonal relationships are responsible and intense. The individual is preoccupied with inner feelings and achievement.
6. **Autonomous Stage** – Inner conflicts, differences, and ambiguities are successfully dealt with and tolerated. Maintaining autonomy in interpersonal relationships is a concern. The individual is preoccupied with self-fulfillment and role definition.
7. **Integrated Stage** – Unattainable/unrealistic goals are put aside. Conflicts are reconciled. Individuality is cherished in interpersonal relationships. The individual is preoccupied with achieving an integrated identity.

Loevinger noted that few people achieve the last two stages.

VI. William G. Perry

Perry's (1970) **cognitive-developmental** sequence of stages identifies **intellectual** and **ethical** development in college students. This model begins where Piaget's stopped with late adolescent development.

Perry's four levels of development correlate the developmental interrelationship of a student's concept of the world and of the nature of knowledge with the student's sense of identity, value, and meaning of his or her role in the world:

Level 1: **Dualism** – The person views the world in concrete, discrete, absolute terms. Alternative perspectives are acknowledged but not acted upon or accepted.

Level 2: **Multiplicity** – The person is able to view the world from multiple perspectives. During this level, however, the person lacks the ability or criteria to evaluate and resolve conflicting or coexisting points of view.

Level 3: **Relativism** – The person understands that knowledge and values are relative and contextual. Now “students see the big picture.” Analytical thinking, acceptance of others' authority and value judgments, and evaluation of ideas, both of self and others, mark this level.

Level 4: **Commitment in Relativism** – The person takes the responsibility to establish an identity in a pluralistic world. Personal commitments such as those made in marriage, religion, and a career are evidence of both an internal value system and consistent external lifestyle choices.

VII. Robert Kegan

Kegan (1982) provides a **life-span developmental** model in which the individual is continually trying to “**make meaning**” or make sense of his/her experience. This constant cognitive thought procedure results in growth.

Kegan uses the term “**holding environment**” in counseling to describe the place/environment/setting in which the client can make meaning regarding a crisis and can discover new direction.

Kegan suggests six stages of life span development:

1. incorporative
2. impulsive
3. imperial
4. interpersonal
5. institutional
6. interindividual

VIII. Robert Havighurst

Robert Havighurst (1951) theorized a six-stage model of developmental tasks. As the tasks are mastered, healthy growth and development are realized. These **tasks must** be taught effectively at the appropriate times in life in order for the next tasks to be mastered. He delineated tasks and stages from **birth to death**. In children, for example, these tasks allow the child to develop conscience, morality, and a range of values or learning to get along with age mates.

Individuals have **teachable moments** that occur at sensitive periods or times which allow the acquisition of a skill.

Society will guide the individual in acquiring appropriate skills at appropriate times.

These developmental skills are best learned in the appropriate sequence. Otherwise, the skill will be difficult to acquire at a later time.

Adolescent development encompasses eight developmental tasks:

1. Accepting one's physique and accepting a masculine or female role
2. Forming age/mate relations of both sexes
3. Independence of emotions from mother and father as well as other adults
4. Occupational selection and preparation
5. Achieving civil competence via intellectual skills and concepts
6. Acquiring socially responsible behavior
7. Preparing for marriage and family life
8. Conscious values in harmony with the current world

Havighurst is perhaps best known for his delineation of **four stages of adulthood**:

Stage 1: **Early Adulthood** (about ages 18 to 30)

- Tasks:
- Explore intimate relationships and start a family
 - Explore and begin a career
 - Explore and find a compatible social group

Stage 2: **Middle Adulthood or Middle Age** (about ages 30 to 60)

- Tasks:
- Manage career
 - Nurture the marital relationship, social relationships, and the household

Stage 3: **Later Adulthood or Later Maturity** (about ages 60 to 75)

- Tasks:
- Accept new roles and activities
 - Accept life
 - Formulate a viewpoint on death

Stage 4: **Very Old Age**

- Task:
- Coping with physical changes

INFORMATION PROCESSING THEORIES

Research into **computer programming** has sparked a stream of cognitive development theorists that view humans as having mental hardware and mental software.

- **Mental hardware** denotes the cognitive structures and memories where information is stored.
- **Mental software** denotes organized sets of cognitive processes that instigate specific tasks such as reading a word or playing a violin.

Just as computer technology has increased through the years, the older children and adolescents have “**better**” **hardware and software**, thus **accounting for cognitive development**. Some theorists put the blame for mental aging on deteriorating mental hardware and a declining mental software (Kail & Cavanaugh, 2001).

Information processing theorists **do not view cognitive development as a predictable sequence of steps or stages**. Instead, emphasis is on **how information is processed**:

1. How it enters the mind
2. How it is stored
3. How it is transformed
4. How it is retrieved to perform such activities as problem solving and reasoning

There is a continuity and flow between cognitive processes and processes may overlap (Santrock, 1999).

Current research indicates that cognitive development is much more specific than theorists like Piaget thought. For example, information processing psychologists believe that infants are either born with conceptual capabilities or can grasp concepts much earlier than was thought by Piaget.

Memory, attention, and problem solving are some of the focus areas applicable to this model.

No one theorist has spearheaded the information processing theory movement. Some of the theorists that are quoted in recent texts concerning information processing theory are:

1. **Robbie Case** (1985) argues that **cognitive processes** increase as capacity to process information increases.
2. **John Flavell** (1992) has pioneered research in **how children think** including their use of rehearsal as a control process.
3. **R. S. Siegler** (1998) has evaluated **children’s problem solving abilities** and has concluded that children and scientists use similar methods since they both ask basic questions.
4. **Andrew Meltzoff** (1990) has conducted numerous studies of **infants’ imitative** abilities.
5. **Robert J. Sternberg’s** (1986) **triarchic theory of intelligence** states that intelligence has three factors:
 - a. Componential Intelligence is analytical thinking that is easily validated by traditional IQ tests.
 - b. Experiential Intelligence is insightful, creative thinking that may or may not score well on traditional IQ tests.
 - c. Contextual Intelligence is practical know-how and street smarts.

BEHAVIORAL THEORIES AND SOCIAL LEARNING THEORIES

(Includes Learning Theories)

Behavioral and social learning theories **emphasize** the significance of **environmental factors**, rather than biological or cognitive factors, as determining causes of development.

Empiricism is often considered the forerunner of behaviorism. The word comes from the Greek word meaning experience and the philosophy believes that experience is the source for acquiring any knowledge; quantitative changes are the only basis of statistical studies. The empiricist influence has led some behaviorists to say “if you can’t measure it then it doesn’t exist.”

I. Classical Conditioning/Respondent Conditioning

A. Ivan Pavlov

Pavlov (Hunt, 1993) discovered the associative learning process of classical conditioning as he experimented with dogs. He asserted the important role of antecedents (preceding events or conditioning) in producing behaviors and held that some antecedents (i.e., unconditioned stimuli) produced unconditioned, or natural, responses.

Before conditioning, the dog food (UCS) produces salivation (UCR). During conditioning, the dog food (UCS) is paired with a ringing bell (neutral) so that the bell becomes the conditioned stimulus (CS) producing salivation (CR). After conditioning, the bell (CS) produces salivation (CR).

Important concepts pertinent to classical conditioning include the following:

1. **Acquisition** – the period during which the organism learns the association between the conditioned stimulus and the conditioned response.
2. **Conditioned Response (CR)** – the learned response to a conditioned stimulus.
3. **Conditioned Stimulus (CS)** – a stimulus that, through repeated pairings with an unconditioned stimulus (UCS), acquires the capacity to evoke a response it did not originally evoke.
4. **Counter-conditioning** – a negative conditioned stimulus is paired with a pleasant stimulus that elicits a response that is incompatible with the unwanted conditioned response.
5. **Discrimination** – learning to make distinctions among similar stimuli.
6. **Extinction** – the reduction in response that occurs when the conditioned stimulus is presented without the unconditioned stimulus. (This parallels the stage in Operant Conditioning when reinforcement is no longer given.)
7. **Stimulus Generalization** – the showing of a given behavior toward similar stimuli once an organism has learned to associate a given behavior with a specific stimulus.
8. **Spontaneous Recovery** – the recurrence of the previously extinguished conditioned response following a rest period.
9. **Unconditioned Response (UCR)** – a response that occurs to an unconditioned stimulus automatically without requiring any learning.
10. **Unconditioned Stimulus (UCS)** – a stimulus that naturally and automatically elicits an unconditioned response.
11. **Contiguity** – if two events occur at the same time, a connection between the two is made.
12. **Contingency** – the occurrence of one event is dependent (contingent) upon the occurrence of another event; this dependency relationship is foundational to classical conditioning.

B. John Watson

Watson is regarded as the **father of behaviorism**. He found the classical conditioning methods Pavlov used with animals to be very useful in treating phobias in humans.

He believed that the only subject matter for psychological study was observable behavior.

Watson was convinced that a person's behavior could be **shaped** through conditioning; moreover, **he was convinced that a person's behavior is shaped through conditioning from birth.**

The mind of the infant, he proposed, is a *tabulae rasae* or a “**blank slate.**” **He or she inherits only three basic emotions: fear, love, and rage.**

Environmental factors condition the person as to how to feel, what to think, how to act, etc. Watson believed that learned habits (associations between stimuli and responses) are foundational to personality development.

In Watson and Raynor's “**Little Albert**” experiment, Watson demonstrated that an unlearned fear of a loud noise could, through conditioning, come to be evoked by a previously unfeared white rat, thus providing a model for the development of the emotions (Corsini, 1984).

C. Clark Hull

Clark Hull's fame stems from his development of a conceptually tight and mathematically-oriented **theory of motivational processes (drive)**. It was considered a masterpiece of theory construction when it was published.

- Hull believed that man is basically a survivor. Any life-threatening situation, according to Hull, prompts man to respond in such a way as to insure his continued existence. His response may be innate or learned.
- Situations that threatened survival were physically defined as consisting of primary biological drives such as hunger, thirst, pain, and sex.
- According to the theory, stimulation associated with any of these variables arouses behavior that aims to reduce or eliminate the stimulation. This learned association between the drive and the behavior that reduces it is called a “**habit.**”

While Hull's hypotheses have been put in question by further research, his work is important because it provided the **basis for an objective and mathematical model of motivation**. It stimulated its proponents as well as its opponents to further research. Hull insisted on well-constructed experiments and on the quantification of the resulting data (Corsini, 1984).

D. Joseph Wolpe

Wolpe theorized that all neurotic behavior is an expression of **anxiety**. Psychosis is learned.

Wolpe found classical conditioning theory useful in psychotherapy as he initiated the concepts of reciprocal inhibition and systematic desensitization, techniques which served to reduce anxiety. His treatment paired relaxation with an anxiety-provoking stimulus until the stimulus no longer provoked anxiety.

Pavlov's Dogs

Before Conditioning

Unconditioned Stimulus



food



Unconditioned Response



salivation

During Conditioning



●●●●●
Conditioned Stimulus
sound of bell



food



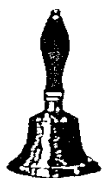
Unconditioned Stimulus

Unconditioned Response



salivation

After Conditioning



sound



Conditioned Stimulus



salivation

II. Operant Conditioning/Instrumental Learning

A. Edward Thorndike

Thorndike first formulated the **law of effect**, sometimes called “trial and error learning,” which basically stated that

- a consequence of behavior
- a reward (a satisfying result)
- a punishment (an unpleasant, annoying result)

determined whether the strength of a stimulus-response connection was either increased or decreased. Thorndike was fundamentally an associationist; his law of effect was founded in connectionism (the stimulus-response connections that were “successful” by “chance” rather than by “insight” or rational analysis) (Corsini, 1984).

B. B. F. Skinner

Skinner innovatively renamed Thorndike’s law of effect **the principle of reinforcement** and designated this type of learning as **operant conditioning**.

Skinner asserted that learning occurs as individuals encounter (experience) the consequences of their behaviors, either reinforcement or punishment.

In Operant Conditioning, the behaviors increase or decrease in frequency as the result of the application of or the withdrawal of a reward; this is known as **reinforcement**.

1. Types of reinforcements

- Positive** – a consequence that is added, thereby strengthening the response that precedes it by virtue of its presentation. (**Examples:** stickers on good school work; payment for work; compliments for accomplishments)
- Negative** – a consequence that is withdrawn or terminated thereby strengthening the response that precedes it by virtue of its removal or termination. In other words, when a negative event is removed, the desired behavior takes place. (**Examples:** Being released from detention hall early for good behavior. Skinner's rats were continuously shocked until they pushed a bar that turned off the current. Turning off a shock is a negative event because it takes away a stimulus. Since removal of the shocks increases the likelihood that a rat will push the bar again, the event is reinforcing.)
- Primary** – an event with reinforcing qualities that are barely dependent, if dependent at all, on prior learning. (**Example:** food).
- Secondary** – an event that is not inherently pleasant or reinforcing but it becomes so through its association with other reinforcing stimuli. (**Example:** money – currency is not in itself reinforcing, but the things money can buy are; token economies work the same way)
- Partial or intermittent** – reinforcement that occurs only sometimes, not every time the desired response is given.
- Punishment** – an aversive stimulus used repeatedly to produce avoidance behavior.

2. Schedules of reinforcement

Timing and timeframes are key factors in operant conditioning. The chosen schedule or rate of reinforcement profoundly affects the rate of response. Any discussion or explanation of operant behavior must take time into account.

Reinforcement can be presented in a continuous or intermittent pattern. Continuous reinforcement schedules, where each correct response is reinforced, are rarely employed because they yield the worst long-term learning results.

Therefore, schedules of reinforcement are considered to be established plans for allotting reinforcements under partial or intermittent schedules. Partial or intermittent reinforcement can be scheduled in these four formats:

- a. **Fixed-interval schedule:** Reinforcement is given after a certain fixed period of time. The amount of work done (the number of responses) does **not** effect when reinforcement is given. In other words, the reinforcement is given at set times (or a set time period) regardless of how much work is done.
FOR EXAMPLE: Generally speaking, people who receive a salary fit this category. They receive a paycheck at a specific time each month regardless of the amount of work they do. They do not get their paycheck earlier by standing around at the payroll window or by repeatedly asking/begging to get it early. They are paid (reinforced) at a pre-determined time or at a fixed interval.
- b. **Variable-interval schedule:** Reinforcement is given at variable (unpredictable) intervals of time. FOR EXAMPLE: Let's say you are attempting to call a friend and get a busy signal several times. So, you begin to place the call based on your best "guess" of when they will be off the line. But no matter how often or when you dial, the length of time (the variable) your friend stays on the phone (let's say 7 minutes) determines when you will be rewarded (i.e., finally reach your friend). The next time the phone line is busy, he/she may be on the phone 3 minutes; and then you get rewarded. The following time he/she may be on the phone 13 minutes.
- c. **Fixed-ratio schedule:** Reinforcement is given after a set number of responses are performed.
FOR EXAMPLE: Let's say you are hired to sew short sleeve shirts and are told you will be paid after completing every twelfth shirt. Upon completion of the 12th shirt you are paid (being reinforced). You are not paid after the 3rd shirt, the 7th shirt, or the 9th shirt. You are paid only after you sew 12 shirts, 24 shirts, 36 shirts, etc.
- d. **Variable-ratio schedule:** The number of responses required before being reinforced is unpredictable/continually changing.
FOR EXAMPLE: Let's say you are sitting at a slot machine putting in quarters. You know that there is a chance of winning. However, you don't know how many quarters you'll have to put in before winning. Sometimes you win after 7 quarters. Sometimes you win after 777 quarters. Sometimes you win after 7,777 quarters.

Some Important Terms To Remember:

1. **Successive approximation** – increments of change toward a desired behavior are reinforced, thereby **shaping** the response into the desired behavior (Example: Language development – a baby makes a small sound; mom smiles and says words that sound like the infant's. This continues until the infant makes a sound that is a recognized word.)
2. **Token Economy** – a medium of exchange for the giving or withdrawing of positive reinforcers.

Just For Fun

Skinner constructed what came to be known as an **air crib** for his younger daughter. Air was filtered so that air-borne viruses and germs were practically eliminated from her crib environment. Even though the girl was out of the crib often just like any other child is, she did not contract viral infections when other members of the family were sick. Skinner attributed this to her filtered crib. One side of the crib was made of safety glass so the child had an unobstructed view of the room. The crib was featured in a 1940's edition of a ladies' magazine and generated about the same number of positive "Letters to the Editor" as letters decrying its *Brave New World* implications.

A COMPARISON OF CLASSICAL AND OPERANT CONDITIONING

CHARACTERISTIC	CLASSICAL CONDITIONING	OPERANT CONDITIONING
1. Stimulus response sequence:	The stimulus precedes the response. (Alarm clock goes off – you are startled)	The response occurs prior to the effect (reward). (Child tries to help you. You either say "Thank you" or "Just leave me alone.")
2. Role of stimulus:	The response is elicited. (Elicited by alarm clock)	The response is emitted. (Attempt to help made prior to feedback)
3. Specificity of the stimulus:	A specific stimulus results in a particular response.	No specific stimulus produces a particular response.
4. Process:	One stimulus substitutes for another.	A substitution in stimuli does not take place.
5. Content:	Emotions such as fear are primarily involved.	Goal-seeking activity is primarily involved.

Notice these differences in the views toward development held by the Stage theorists as opposed to the Classical, Operant, and Vicarious Conditioning theorists:

Stage Theorists	Conditioning/Learning Theorists
Believe development proceeds in a sequential, fixed manner.	Believe development proceeds in a less sequential and more random fashion.
Stress the predictable continuum of operations in effect at various stages.	Stress variations in learning.
Focus on the changes occurring in a child's psychological structure.	Focus on processes that function all through the life cycle.
Emphasize internal motivations.	Emphasize external environmental forces.

III. Vicarious Conditioning

Also known as: **Social Learning Theory**
 Observational Learning
 Linear-Interactionist Social-Cognitive Theory
 Cognitive Social Learning Theory

Whichever name is used, social learning theories contend that people learn patterns of behavior through observing and interacting with others.

Proponents of the social learning approach tout its objectivity, its practical applications, and its generation of much valuable information regarding the development of children and adolescents.

Critics of the social learning approach emphasize its disregard and discounting of biological and cognitive elements in the personal and social development of individuals.

A. **Albert Bandura**

Bandura developed his **social learning** theory based on his belief that an individual learns new behaviors by identifying with and imitating others (models).

1. **Systems of Control**

Bandura stated that three systems control behavior. Theoretically, behavior is controlled by one of the three systems. In reality, most behaviors result from a combination of two or all three of these systems:

a. **External stimuli control**

Reflexive behavior produced by:

- environmental stimuli (dust = sneeze)
- conditioned stimuli (blink when puff of air is blown in eye; then add buzzer with every puff of air = blink with buzzer alone)
- responses controlled by stimuli present at the time of reinforcement or punishment (a child reinforced for a behavior in one setting and punished in another, i.e. yelling on the playground is acceptable; yelling at a funeral is not)

b. **Outcomes Control**

Consequences of behavior, including all reinforcing feedback concerning the appropriateness of the behavior, affect future behavior (bouncing checks at the bank).

c. **Symbolic or Internal Control**

Imagining or self-instruction that allows an individual to visualize or to predict the outcomes and long-range consequences of various behaviors (saving money for a down payment on a house).

2. Modeling Processes

“Modeling,” or the acquiring of learning through observation, occurs through four processes:

- a. **Attention** – Learning does not occur by exposure alone. The learner must pay attention to the model. Variables affecting the learner’s attention may include the likeability of the model, prior reinforcement for attending to similar models, the psychological state of the observer, the complexity of the modeled behavior, etc.
- b. **Retention** – The learner must have the capacity to recall his or her memory of the modeled behavior. The learner will have appropriately used visual imagery or verbal coding to symbolically plant the modeled behavior in memory.
- c. **Reproduction** – The learner uses memory to guide an actual performance of the behavior. The accuracy of the reproduced or rehearsed behavior will be naturally limited by the physical ability of the learner.
- d. **Motivation** – Reinforcement, either internal/self-reinforcement or external, is required for behavior to be retained and regularly manifested.

3. Vicarious Nature of Learning

The premise that learning can be vicarious (achieved by observing others and modeling or imitating the observed behavior) is a key characteristic of social learning theory.

In **primary vicarious conditioning**, the model goes through classical or instrumental conditioning while the observer watches the stimulus, the response, and the consequence.

In **secondary vicarious conditioning**, the stimuli, response, and consequence are represented symbolically, not actually demonstrated.

The direct conditioning procedures laid out in the classical and operant conditioning theories can be used to change or modify behavior that was acquired vicariously (through observation).

B. George Kelly

Kelly's (1955) system of **personal constructs** is based on Kelly's belief that an individual's own concepts or constructs are created by the individual in an effort to understand the individual environment. **Constructive alternativism** is an important determinant of one's decisions and behavior.

C. Edwin R. Guthrie

Guthrie's (1952) **One-Shot Learning theory** challenged the belief that learning is a gradual process requiring repeated reinforcement. He asserted that immediate learning occurs: The same movement will tend to re-occur when the stimuli and movement have been previously paired.

1. Principles Underlying Guthrie's Law of Learning

- a. Learning occurs without reinforcement.
- b. Learning occurs in an all-or-nothing fashion:
 - All stimuli that occur contiguously with a response become conditioned to that response in a single trial.

2. Summary Comparison of One-Shot Learning vs. Classical Conditioning

Classical Conditioning – Repeatedly pairing the CS and UCS strengthens the CR. The UCS functions as a reinforcer.

One-Shot Learning – The function of the UCS is to produce an UCR that occurs closer in time to the CS than would occur without the UCS. Thus, based on the theory of contiguity, a CS results in a CR.

3. Comparative View of Practice (which results in stronger behaviors)

Classical Conditioning – Repeated trials result in repeated pairings of the CS and the UCS. Repeated conditioning trials result in stronger CRs.

One-Shot Learning – Practice increases the likelihood that a particular action will occur. It does not affect the likelihood that the same movement will occur in the presence of some stimulus. Learning occurs in one trial, and the strength of the learned association is as strong as it will ever be. Additional practice does not strengthen the learned association.

4. **Guthrie's View of Habits**

To Guthrie, a **habit** was a stereotyped, predictable pattern of responding; a complex act that consists of several chains of S-R connections.

He defined an **act** as the particular response that we choose to measure.

A **movement** was any behavior that results in an act.

Therefore, a single response is a sequence of actions, actions that are chains of responses producing additional stimuli that in turn result in additional responses that act as stimuli for other responses...and on and on.

5. **Extinction or Forgetting**

Whereas Classical Conditioning terms forgetting as a result of extinction, Guthrie believed that forgetting was a result of an extended time lapse between associations. The passage of time does not wipe out the associations but provides opportunity for the new learning to replace the old.

6. **Breaking of a Habit**

Guthrie postulated that a habit could be broken in one of three ways:

- a. **Fatigue Method** – Repeatedly present the stimulus until the organism becomes tired of emitting the response. Once this occurs, a new response will replace the old response.
- b. **Threshold Method** – Present the stimulus that produces an undesirable response but present it at such a level that the undesired response is not emitted. Then increase the intensity of the stimulus (without the organism's awareness) until a new response is emitted to the stimulus and thus replaces the old response.
- c. **Incompatible Stimuli** – Present the stimulus at such a time that the response cannot occur. If the undesirable response cannot occur, another response will be emitted and then will replace the undesirable response.

Question – What is the opposite of empiricism?

- Just as the term empiricism is used to classify behavioral theories that insist on the measurement of quantitative changes, the term organicism is sometimes used to classify the more holistic theories that accept qualitative changes.
- Organicists feel that internal change is appropriate and needed. Heredity, the environment, and the individual's actions are of combined influence and importance.

THE MEASURING OF PERSONALITY (TRAIT THEORIES)

I. Henry Murray

Murray's (1938) theory endeavored to predict human behavior by basing human motivation on two kinds of needs:

1. basic, or primary, needs
2. learned, or secondary, needs

As one attempts to meet these needs, **press** (external events) may either interfere with or help in the fulfillment of the need. The combination of need and press is called **thema**.

The following tests are based on Murray's work:

- The Thematic Apperception Test (TAT)
- The Edwards Personal Preference Schedule (EPPS)
- The Children's Apperception Test (CAT)
- The Senior's Apperception Test (SAT)

II. Gordon Allport

- Allport's (1965) theory assumes **traits** to be the fundamental and relatively stable units of personality.
- According to Allport, one's personality changes throughout one's life based on one's internal characteristics—goals, purposes, intentions, etc.
- This dynamic process is in direct opposition to behaviorists who say that change was only a response or reaction to external proddings.
- Personal traits can be graphed by their progressive prominence from **specific**, a particular behavior, to **general**, that particular behavior having become a habit.
- Allport's three types of traits are:
 1. common
 2. personal
 3. cardinal

III. Raymond Cattell

- Cattell's (1946) contribution was to compile a list of 171 **surface traits** (observable individual differences in personality) for rating individuals.
- Using factor analysis and intercorrelation of ratings, Cattell then consolidated the traits into 16 underlying **source traits** or dimensions.
- Cattell's work resulted in the Sixteen Personality Factor Questionnaire (16PF) which measures source traits in individuals.

ETHOLOGICAL, BIOLOGICAL, AND PHYSICAL THEORIES (INCLUDES ATTACHMENT THEORY)

I. H.F. Harlow

Harlow's (1959) study (Harlow and Zimmerman rhesus monkey study) looked at the **bonding** process or **contact comfort** using infant monkeys and cloth substitute mothers.

- The researchers discovered that these infant monkeys became attached to terry cloth mothers.
- They clung to cloth substitutes in strange environments or in other stressful situations.
- They preferred artificial mothers that rocked over ones that did not move.
- They preferred warm substitute mothers over cold ones.
- The fact that the mother provided food was neither necessary nor enough to establish attachment.

Monkeys kept in isolation displayed autistic abnormal behavior. Some remission of this dysfunctional behavior was observed when these monkeys were then housed with a group of normally reared monkeys. Harlow concluded that attachment is an innate tendency not a learned behavior.

II. Renee Spitz

Renee Spitz drew similar conclusions to Harlow for humans by observing children raised in impersonal, institutional settings.

- **Anaclitic depression** was defined by Spitz as the listlessness, crying, and withdrawn behavior displayed by infants separated from their mothers for at least 3 months. These children cried more, had difficulty sleeping, and experienced more health-related problems.
- Such children develop **hospitalism** due to maternal deprivation (lack of bonding); that is, developmental retardation occurs due to a lack of normal stimulation in the environment. These infants would have problems forming close relationships later in life.

III. Konrad Lorenz

Lorenz (1965) found that a brief period of irreversible **imprinting (bonding)** occurs during a **critical period** (a time period in which a particular behavior must be learned, or it won't be acquired or learned at all).

- His experiment involved goslings where he became the first moving object they saw, instead of their mother. The goslings followed him around instead of their mother.
- **Imprinting** is an **instinctual** behavior. Instinctual behaviors are sometimes called “**species-specific**” meaning that every member of that species exhibits that behavior trait.
- Lorenz believed that certain behaviors such as **aggressiveness** are **inborn tendencies**, a part of our evolution, and are required for our survival. He said we are like the baboon or wolf in that regard.
- He suggested the catharsis of activities like competitive sports to deal with modern day aggression.

IV. John Bowlby

Bowlby's study emphasized the adaptive function or adaptive significance of attachment. In other words, bonding and attachment are necessary for survival. Parents act as a “releaser stimulus” to evoke relief from hunger and tension through holding.

- He related failure to form early attachments (by age three) with a primary figure to later inability to form close social relationships. (He was the first theorist to provide a theory of sociopathic development.)
- An early, severed bond results in **object loss** which is thought to initiate abnormal behavior.
- Adult psychosis (sociopath) can result from thwarted symbiotic relationships.

Adaptation to prolonged separation from a caretaker has three stages:

1. **Protest** – will not accept the separation; screams, cries, etc.
2. **Despair** – gives up hope of reconciliation; becomes quiet, inactive, and withdrawn.
3. **Detachment** – accepts attention from others; seems less unhappy; is unmoved by the caretaker returning.

Today's counselors would probably not agree with Bowlby's thoughts on the roles of mothers and fathers. As a British psychoanalyst of the early 1950s, he thought that the mother should be the primary caregiver. He did not see the father as a co-nurturer of the child. Instead, the father's role was to emotionally support the mother.

V. Mary Ainsworth

Ainsworth developed the **Strange Situation**, the most widely used setting for observing infant responses. The Strange Situation is an observational measure of infant attachment that requires the infant to move through a series of introductions, separations, and reunions with the caregiver and an adult stranger in a prescribed setting (Kail and Cavanaugh, 2001).

After observing infants as they were separated from and reunited with their caregivers, Ainsworth identified **four attachment behavior types**:

1. **Secure attachment** – The baby uses the mother as a secure base from which to explore the environment.
2. **Avoidant attachment** – The baby ignores the caregiver, avoids direct contact.
3. **Resistant attachment** – The baby resists the caregiver, perhaps kicks and pushes away.
4. **Disorganized attachment** – The baby seems confused, may physically approach the mother but not look at her.

Ainsworth also identified **four stages of attachment** in human infants:

1. **Social Responsiveness** – For the first two to three months of life, the infant uses signaling behavior to establish contact with others. At three to six months, the primary caregiver becomes the focus of the signaling.
2. **Discriminating Social Responsiveness** – From two to seven months, the infant begins to show a preference for a familiar person.
3. **Active Proximity Seeking** – From seven months to two years, the child actively seeks close contact with the caretaker. Later, attachments with others develop.
4. **Partnership Behavior** – In the third year, the relationship between the child and the caretaker evolves into a give-and-take relationship. The child perceives the caregiver as a separate person and begins to adjust behavior and expectations based upon another person (Kail and Cavanaugh, 2001).

VI. Arnold Gesell

Gesell used the theory of **maturation** to explain common developmental patterns that are internally controlled rather than influenced by the external environment. He believed that development progresses sequentially (Zastrow, Kirst-Ashman, 1987).

Terms associated with Gesell include:

- **Day Cycle** – Everyday abilities expand; growth occurs.
- **Self-Regulatory Fluctuations** – Growth and instability occur simultaneously moving the child toward maturity.
- **Constitutional Individuality** – Each individual is unique and has his or her own growth pattern/mode.

Through his research, he developed a measure that is used as a clinical tool to help differentiate potentially normal babies from abnormal ones. The version of the test that is currently used assesses four major fields of growth/behavior:

1. **Motor** – Gross bodily control and finer motor coordinations including head balance, sitting, creeping, grasping objects, etc.
2. **Language** – Audible and visual communication including facial expressions, gestures, vocalizations, comprehension of others' communication, etc.
3. **Adaptive** – Eye-hand coordination, fine motor coordination, begins to adjust for simple problems, etc.
4. **Personal-Social** – Cooperativeness, responsiveness to training, feeding abilities, etc.

The subscores for these areas are combined to produce the **developmental quotient (DQ)**. Note that the DQ does not correlate well with IQ scores obtained later in life, probably because the Gesell assessment is not as verbal a test as IQ tests for older children.

VII. Stella Thomas and Alexander Chess

Thomas and Chess list **activity rate, rhythmicity, adaptability to new experiences, general mood, and intensity of response** as products/factors of inherited temperament (Santrock, 1997).

- From observing these characteristics, Thomas and Chess decided that there are three basic types or clusters of temperaments:
 1. **Easy** – Generally in a positive mood, quickly establishes routines, adapts easily to new experiences.
 2. **Difficult** – Generally negative, cries frequently, slow to accept new experiences, has difficulty establishing routines.
 3. **Slow-to-warm-up** – Is somewhat negative, has a low activity level, shows low adaptability and low mood intensity (Thomas & Chess, 1991).

VIII. Gibson's Visual Cliff

That **depth perception** is a learned phenomenon came under fire with Gibson's classic experiment with infants and **the visual cliff**. She placed infants on a large sheet of glass with checked linoleum under half of the glass. Where the linoleum stopped, there appeared to be a drop off or cliff, a deep place. The mothers would stand across from the cliff and try to coax the babies to them. The infants would not come. They perceived the difference.

Younger babies who were not yet crawling were placed on both sides of the cliff, and their heart rates were measured. They, too, perceived the difference.

Similar experiments have been done with chicks hatched with no light and therefore no visual cues as to depth perception. When they are brought into the light and placed in such an apparatus, they also avoid the cliff.

These results have lead researchers to acknowledge that there is obviously an innate predisposition to appropriately judge depth perception.

IX. Jerome Bruner

Bruner believes that **cognitive development** is influenced by such factors as culture, evolution, integration, and language.

1. **Culture** – Technical advances shape the development of intellectual functioning. He sites as evidence the fact that people think differently in our technically advanced culture as compared with the thinking of a few centuries ago. Even during the same time period, more sophisticated cultures think differently than less sophisticated ones.
2. **Evolution** – Bruner believed in evolutionary consistency. Whereas Piaget’s theory was autoplasic (cognitive development is a predetermined unfolding), Bruner takes an **alloplastic** view (development is the result of one’s adapting to other people and objects). Accordingly, technology causes evolution. Bruner concluded that the brain evolved to its larger size due to new selection pressures after the introduction of various tools. Therefore, movements, perceptions, and thoughts depend upon technique rather than upon pre-wired arrangements in the nervous system (Fogiel, 1989).
3. **Integration** – Bruner believed that there are few simple, individual adult acts that cannot be performed by a child. He theorized that cognitive maturation results from integration of acts and skills and what he called “blueprints” or plans of higher order combinations. He asserted that language is the means by which such plans are generated, not the other way around.
4. **Language** – **Bruner considers language acquisition to be the chief milestone in cognitive development.** He theorized that people convert immediate experiences into cognitive representatives in three fundamental ways or stages:
 - a. **Enactive mode** – Objects have meaning only with respect to the actions performed on them (infant sees bottle as having a pleasurable liquid inside).
 - This is the first stage to develop.
 - b. **Iconic mode** – Knowledge is based heavily on images which stand for perceptual events (a picture stands for an actual event).
 - This is the second stage to develop.
 - c. **Symbolic mode** – Language provides the means for representing experience and for transforming it.
 - This is the last stage to develop, and most adult thought is in the symbolic mode.

X. William Sheldon

Sheldon's **constitutional** personality theory (**somatotyping**) stated that development occurs through a relationship between **body types** and **temperaments**. He places human development into three major body types (Hunt, 1993):

1. **Ectomorphy** – a long, stringy, skinny body
2. **Mesomorphy** – a good, developed, stocky, muscular body
3. **Endomorphy** – a round, plump, soft, heavy body having a heavy trunk (visceral weight)

Note: This is an old theory that is virtually ignored today. It is important to know this much about the theory.

XI. Additional Miscellaneous Data

1. Stranger anxiety begins at approximately 8 months. The child shows fearful responses to strangers.
2. Separation anxiety begins at approximately 12 months. The child shows fear when left behind by a primary caretaker.
3. Ethology originated in Europe as zoologists endeavored to apply Darwinian theory to behavior. Today ethology refers to field research utilizing animals.

AN OVERVIEW OF GROWTH AND DEVELOPMENT

I. Physical Beginnings

The journey of development begins at conception as a spermatozoon joins an ovum to create a fertilized egg (zygote). Chromosomes (23 pairs) containing deoxyribonucleic acid (DNA) reside in each human cell. DNA is a complex molecule of genetic information. Genes, short segments of DNA, function as a blueprint for cells to divide, reproduce themselves, and manufacture the protein necessary to sustain life (Santrock, 1999).

After fertilization, rapid cell division (**mitosis**) begins, and the zygote attaches to the uterine wall becoming an embryo. If the fertilized egg has split in two, **identical twins (monozygotic)** are the result. If, however, two separate eggs are fertilized by two different sperm, **fraternal or dizygotic** twins will be born.

II. Factors Influencing Prenatal Development

During the embryonic (second through eighth weeks) and fetal stages (last seven months on average) of pregnancy, maternal characteristics and external environmental forces (**teratogens**) have a major effect on the baby's development.

A. Maternal Characteristics

1. **Mother's Age** – Statistics show that **two age groups have more problems:**

- **Adolescent mothers** often have premature babies, and the mortality rate of infants born to adolescent mothers is double that of mothers in their twenties.
- **Mothers over 30** have an increased risk of delivering a Down syndrome baby. Also, infertility rates increase.

2. **Nutrition** – A proper diet is vital since the mother is the sole source of nutrition throughout prenatal development. Proteins, vitamins, and iron are essential. Studies show that a poor diet can affect the central nervous system development and cause premature and underweight births. Research has shown a direct connection between low birth weight and physical and neurological defects including low IQ.

3. **Emotional State and Stress** – Pregnant women who experience prolonged, severe stress are more prone to give birth to premature babies or babies who are more hyperactive and irritable.

B. External Hazards to Prenatal Development

Exposure of a developing embryo or fetus to certain environmental factors can damage the developing organism or even cause death. A **teratogen** (terato means monster) is any agent or influence that causes developmental defects in the embryo or fetus.

1. **Maternal Diseases** – Maternal diseases or infections can produce defects by crossing the placental barrier. They can also cause damage during the birth process itself.
 - **Rubella** (German measles) and syphilis can cause birth defects.
 - **Genital herpes** can cause infant death or brain damage.
 - The **human immunodeficiency virus (HIV)** can result in birth defects, illness, acquired immune deficiency syndrome (AIDS), and death of the newborn.
2. **Drugs** – Since the placenta is a porous barrier between the maternal and fetal circulations, any drug or chemical dangerous to an infant may be considered potentially dangerous to the fetus when given to the mother.
 - **Alcohol** usage can result in **fetal alcohol syndrome**, a cluster of abnormalities including facial deformities and defective limbs, face, and heart.
 - **Cigarette smoking** (nicotine) often causes lower birth weights and pre-term births.
 - **Aspirin** usage can cause intelligence, attention, and motor skill deficits.
 - **Caffeine** can result in lower birth weight and reduced muscle tone.
 - Other drug usage (**marijuana, heroin, cocaine, amphetamines, barbiturates**, etc.) compromises the health of both the mother and the baby and increases the risk of birth abnormalities, hyperirritability, crib death, spontaneous abortion (miscarriage), and still birth.
3. **Environmental Hazards** – Toxins and chemicals associated with industrial waste surround us in our industrialized society. People are many times unaware that they have been exposed. These environmental teratogens have been identified as current hazards:
 - **Lead** exposure can cause mental retardation.
 - **Mercury** exposure can result in cerebral palsy, mental retardation, and retarded growth.
 - **PCB** (a manufacturing chemical) exposure can cause visual discrimination and memory skill problems.
 - **X-rays** can cause retarded growth, mental retardation, and leukemia.

Health professionals and social policy makers are increasingly targeting prenatal education and prenatal care in hopes of increasing the numbers of healthy babies born and reducing the numbers of at-risk pregnancies and births.

III. Generally Accepted Assumptions About Physical Growth

- A. Growth is: **cephalocaudal** (from head to tail) and **proximodistal** (from the center to the extremities).
- B. Infancy, early childhood, and adolescence are the three periods of accelerated physical growth.
- C. The extent and pattern of growth is predictable due to its biological nature.
- D. Motor and perceptual skills develop from the simple to the complex.
- E. Maturation alone does not guarantee skill development.

Note: Research has shown that a biological readiness must exist for maximum skill acquisition to take place.

IV. Critical Details of Central Nervous System Development

- The central nervous system consists of the spinal cord and brain.
- At birth, the brain is only 25 percent of its adult weight and size.
- By age two, the brain is at 80 percent of its adult weight.
- Growth is a result of adding new neurons, increasing the interconnections between the neurons, and adding glial cells which orchestrates the myelination of nerve fibers.
- By age 16, the brain has reached its adult size and weight.
- At birth, the brain stem and diencephalons (back areas of the brain) are mature enough to sustain the reflexes needed to maintain life.
- From birth to about age 16, the cerebral cortex develops allowing higher-level cognitive functions and complex motor activities.
- The brain begins to lose neurons and shrink at around age 30. Sensory and motor activities are affected the most.
- By age 90, the brain has shrunk about 20 percent from its size at age 30.
- Research indicates that while reduced blood flow and a decrease in neuro-transmitters are evidenced with aging, the brain attempts to compensate for these factors by developing new interconnections between remaining neurons. When confronted with new tasks, older brains literally rewired themselves to compensate for losses (Rapaport, 1994).

V. General Issues of the Developmental Stages

A. Birth to 2 Weeks Old – Sometimes referred to as Infancy

1. The first two weeks is a time of radical adjustment for the newborn.
2. Coming from the womb to the outside world requires four major changes:
 - Breathing (umbilical cord to own lungs)
 - Sucking/swallowing to eat
 - Temperature (from mother's body to outside)
 - Elimination
3. This stage is marked by the umbilical cord falling from the navel and the child regaining weight lost at birth.

B. Two Weeks to Two Years Old – Referred to as Infancy or Babyhood

1. Children exhibit a gradual decrease in helplessness.
2. Bonding/attachment takes place (Freud's oral stage; Bowlby).
3. Erikson's trust vs. mistrust stage applies.
4. The child matures into Erikson's autonomy vs. shame & doubt stage.
5. Sleep gradually becomes night sleep for 8 ½ to 10 hours.
6. Emotions are exhibited – anger, fear, curiosity, joy, affection, negativity.
7. Socialization is egocentric (Piaget) and focused on the caregiver (Bowlby).
8. Sex-role typing takes place.
9. Problem-solving and creativity are reinforced by play (Bruner).
10. Morality is by constraint (Kohlberg).
11. Infants prefer new stimuli over familiar stimuli (Novelty Paradigm).
12. Infants show surprise when their expectations are not met (Surprise Paradigm; measured by changes in breathing rates and galvanic skin responses).
13. Infants have depth perception (Visual Cliff).
14. At about 18 months, infants realize that objects continue to exist even when they are out of sight (Object Permanence).

C. Two Years to Six Years – Sometimes called Early Childhood or Preschool

1. Toys are the focus until the school years begin at age 6.
2. Aggressive behavior is influenced by:
 - a. the reinforcers used for the behavior
 - b. the models of aggressive behavior seen by the child
 - c. the amount of guilt or anxiety associated with aggressive behavior
 - It is believed that aggressive children will be aggressive adults.
3. The child learns to deal with frustration.
4. The characteristics of dependency, independence, and autonomy begin to develop in these years based on characteristics of the family's interactions. Confident independent children have consistent, warm, secure family lives.
5. Play is a means of safely exploring and seeking out new information.
6. Mildred Parten's Classic Study of Play (1932)

Parten's **six play categories** emphasize the role of play in the child's social world:

 - a. **Unoccupied play** – Child is not engaged and not interested in play.
 - b. **Solitary play** – Child independently plays alone.
 - c. **Onlooker play** – Child watches others play (with active interest).
 - d. **Parallel play** – Child plays beside others and mimics their play but does not interact with the others.
 - e. **Associative play** – Play involves social interaction with little or no organization. The children are interested in each other (following each other in a line).
 - f. **Cooperative play** – Play involves social interaction in a group with a sense of group identity and organized activity (baseball game).
7. Contemporary researchers emphasize both the cognitive and social aspects of play. Among the most widely studied types of children's play today are:
 - a. **Sensorimotor play** – Behavior engaged in by infants to derive pleasure from exercising their existing sensorimotor schemas.
 - b. **Practice play** – The repetition of behavior when new skills are being learned or perfected. Can be engaged in throughout life.
 - c. **Social play** – Involves social interaction with peers. Includes Parten's categories and rough-and-tumble play.
 - d. **Constructive play** – The self-regulated creation or construction of a product or a problem solution. Requires combining sensorimotor/practice repetitive activity with symbolic representation of ideas.
 - e. **Games** – Activities engaged in for pleasure that include rules; competition with one or more individuals is often included.

D. Six Years to Sexual Maturity – (About Thirteen Years for Girls, Fourteen for Boys) – Sometimes referred to as Late Childhood

1. This is a troublesome era in many ways as identity, independence, and autonomy are sought.
2. Rejecting of parental standards takes place.
3. Acceptance by peers is focal (conformity). Clubs or “gangs” may be formed.
4. Skill development involves self-help, giving and receiving help from others, succeeding in the school environment, and play.
5. Play activities include exploring/curiosity activities, constructive play, games/sports, and collecting everything from more skills to trading cards.
6. There’s generally an antagonistic attitude toward the opposite sex.
7. Reversible thinking is established.
8. Metacognition (monitoring one’s thought processes) is established around age six.
9. The concept of justice evolves to a point of recognizing equity.
10. Racial, ethnic, and religious identities are established.
11. Gender difference becomes an issue. Following are some summary statements regarding currently held beliefs of gender identity development and gender differences through roughly the first 18 years of life.

a. Gender Differences – PHYSICAL/BIOLOGICAL

- (1) Females are less likely to die or to develop physical or mental disorders.
- (2) Males have longer bones and are approximately 10 percent taller than females.
- (3) Similar metabolic brain processes have been recorded except in two particular areas:
 - the area of emotional expression is more active in females (girls are using more “feeling” words even by age two)
 - the area of physical expression is more active in males

b. **Gender Differences – COGNITIVE**

(1) Math Skills

- Maccoby and Jacklin's initial research indicates that males have better **math skills** than females.
- Further evaluation of the data reveals that the math difference does not surface until high school or college and that girls that excelled in math and science have close bonds with their fathers who encourage independence and initiative.
- Also, parents tend to have higher expectations for boys' math and science skills.
- These findings lead some researchers to conclude that such sex-role differences may be largely influenced by parenting styles.

(2) Verbal Skills

- Maccoby and Jacklin's research also indicated that females have better **verbal skills** than males.
- More recent studies are showing that the verbal differences between females and males may be disappearing as evidenced statistically by both males and females scoring high on the verbal portion of the SAT (Scholastic Aptitude Test which is used as a college entrance test).

(3) Visual Perception/Spatial Skills

- The average male's visual perception/spatial skill is higher than the average female's.
- Not all males have better visual perception/spatial skill than all females.

Researchers emphasize that statements regarding gender difference **do not apply to all members** of the gender. Most gender-related assertions are expressing average behaviors; individual performance may be different, i.e. some females have high math aptitudes; some males are very emotional.

c. **Gender Differences – SOCIOEMOTIONAL**

(1) Aggression

Males are more aggressive, are more active, and show less self-regulation of emotions and behavior than females. This may be the result of higher levels of androgen, a male sex hormone.

(2) Suicide

- More males commit suicide than females.
- More females attempt suicide than males.
- Perhaps males are more successful because they will use more lethal means (guns).
- Suicide is the **second or third leading cause of teen deaths every year and the eighth leading cause of death for all Americans.**
- Across the population, the suicide rate is 2/100,000.

NOTE: COUNSELORS MUST TAKE CLIENTS' THREATS TO KILL THEMSELVES SERIOUSLY AS MOST SUICIDE VICTIMS HAVE REVEALED THEIR INTENTIONS BEFOREHAND.

- Testing instruments such as the MMPI and the Rorschach do **not** help identify potential suicide victims (test profiles for suicidal and non-suicidal individuals are similar).

d. **Gender Differences – SEX ROLES**

- (1) Theorists used to believe that the differences between men and women were strictly the outworking of biological factors. Studies have shown, however, that not all gender behavior is biological.
- (2) Gender identities and male/female sex roles have a “learned” component.

e. **Gender Differences – ANDROGYNY**

- (1) **Sandra Bem** has criticized sex role stereotyping and has proposed a model that would allow desirable masculine and feminine characteristics to both exist in an individual.
- (2) She developed the “Sex-Role Inventory” to yield an assessment of personal masculine and feminine qualities. The individual that is neither a sex-typed male nor a sex-typed female but is neutral is termed **androgynous**.
- (3) Gender experts like Bem suggest that androgynous individuals are more competent, flexible, and mentally healthy than their feminine or masculine counterparts.

12. Self-esteem and Parenting Styles

a. Coopersmith

- (1) The development of self-esteem (self-worth or self-image) is the subject of much research. The most extensive study of parent-child relationships and self-esteem was conducted by Stanley Coopersmith with middle-class boys from 10 to 12 years old.
- (2) Coopersmith concluded that parenting practices strongly impact the development of self-esteem.
 - The frequency of punishment or discipline was not a factor (children with high self-esteem were punished or disciplined as often as those with low self-esteem).
 - Children with high self-esteem had more rules to follow.
 - Parents of children with high self-esteem took a more democratic approach to discipline. They focused on the unacceptability of the behavior rather than the “badness” of the child. They listened to the child’s viewpoint and explained the purpose of the rules (Coopersmith, 1967).

b. Baumrind

Baumrind (1971) and her colleagues described three parenting styles in terms of their restrictiveness or permissiveness:

- (1) **Authoritarian** – The parents deliberately try to shape the behavior of the child according to their own standards of conduct. They put a premium on obedience and may use punishment to curb undesirable behavior or rebellion.
- (2) **Permissive** – This style of parenting adopts the policy of keeping hands off and letting children "be themselves" with the hope that this will encourage the child to become self-reliant and develop initiative.
- (3) **Authoritative** – This is the most effective form of parenting. The parents have definite standards, but they also encourage the child to be independent and will solicit the child's opinions at times.

c. Warm vs. Hostile Parenting Styles

Some theorists consider the warm or hostile components of parenting styles along with the restrictive or permissive components (Schaefer, 1959):

- (1.) **Hostile, restrictive** parenting yields socially withdrawn, shy, self-punishing children.
- (2.) **Hostile, permissive** parenting yields disobedient, rebellious, aggressive children.
- (3.) **Warm, restrictive** parenting yields insecure, dependent, uncreative children.
- (4.) **Warm, permissive** parenting yields assertive, tolerant, outgoing, independent children.

Note: While parenting styles affect personality development, some factors seem to be hereditary. Studies of identical and fraternal twins show that basic temperament is substantially genetic.

E. Puberty to 18 – Also called Adolescence

1. Puberty is caused by hormonal changes in both sexes.
 - Girls have first menstruation.
 - Boys have nocturnal emissions.
2. This is a time of rapid physical changes sometimes called growth spurts
 - a. Body size and proportions,
 - b. Emergence of primary sex characteristics
 - enlargement of the genitals or sex organs
 - c. Emergence of secondary sex characteristics
 - pubic hair
 - armpit hair
 - female breast enlargement
 - lowering of voices
 - appearance of facial and chest hair in males
3. Egocentrism pervades this age group.
4. Search for identity with many internal changes.
5. The adolescent must deal with the social consequences of their physical and cognitive changes.
6. Family relationships change (sometimes drastically).
7. The task is to make the transition to maturity.
8. Adolescents seek counseling help with physical appearance issues, heterosexual interests, friendships, and suicide.
9. **Adolescence**, the life stage between childhood and adulthood, is marked by the tasks of physical and sexual maturation, social development, emotional preparation for leaving the family, and continuing intellectual development.

Two tasks of adolescence are:

 - a. **Moving from a dependent to an independent person**
 - b. **Establishing an identity**

10. Most researchers agree that Adolescence falls into three stages marked generally by the following characteristics:

	PHYSICAL CHARACTERISTICS	SOCIAL CHARACTERISTICS	ISSUES
Early Adolescence (11-14)	Primary & secondary sex characteristics originate Oedipal feelings are evident	Attached to family Peer group and out-of-family relationships are important	Demands for growing space Exploring sexual expression Self-absorbed Introspective Possible first contact with drugs Twenty percent have a stormy time
Middle Adolescence (14-17)	Boys catch up with and pass girls in growth Beginnings of focused heterosexual interest are seen	Identifies with group Identifies with same-sex parent Experiences first love	Needs less supervision Needs more money Wants later hours Forming self-identity Sexuality Body image Pregnancy Popularity Male and female stereotyped roles Self-mastery
Late Adolescence (17-20)	Physical maturation continues Develops abstract logical thinking (Piaget's formal operation)	Concerned with the larger world Develops a sense of morality	Decreased introspection Focuses on career and academic future Concerned with social, cultural, theological, ethical, and political issues May be committed to a "cause"

Normal adolescence comes to a close at around 20 years of age. A 24-year-old with adolescent-like behavior is an adult with a problem, not an extended adolescent.

F. School and Education Related Issues

1. Self-fulfilling prophecy

- Rosenthal and Jacobson (1968) presented evidence that students perform better when more is expected of them.
- Subsequent researchers have agreed that teacher expectations and high levels of teacher interaction with the students lead to higher achievement than could be otherwise expected.

2. Compensatory Preschool Programs

- Intelligence is usually the same for children in preschool programs or at home.
- David Elkind (1988) points out that preschool programs are only necessary if the parent does not have the interest or time to provide the child with varied learning experiences at home. If the parent is not able or willing to handle this early education, then a program like Head Start may be beneficial.
- Economically disadvantaged children seem to score higher on achievement tests and have more successful school experiences after attending a compensatory preschool program.

3. Cooperative Learning

- Cooperative learning **improves** academic performance and self-esteem of low-achieving students.
- The technique also decreases stereotyping and prejudice.
- Eliot Aronson formulated the “jigsaw classroom” in which students of diverse abilities or ethnic backgrounds are grouped to work cooperatively on projects (Aronson, 1986).

4. Tracking Students

- Tracking students (grouping students by ability level) has **not proven** beneficial.
- Students placed in lower-performing groups tended not to move up and lost motivation and self-esteem. Perhaps the self-fulfilling prophecy plays a role in this (Goodlad, 1983).

G. Effects of Divorce and Remarriage on Parents and Children

1. Divorce is stressful for all concerned.
 - Considerable distress will be felt by both parents.
 - Relationships with children often deteriorate.
 - The custodial parent will be more restrictive, impatient, inconsistent, and uncommunicative.
 - Noncustodial fathers may be overly indulgent and overly permissive. Visits and child support may decline or stop.
 - Children commonly become more aggressive, noncompliant, and disruptive.
 - Children may experience academic difficulties.
 - Preschool-aged children may experience more difficulties than older children in the short term.
 - Older children suffer more in the long term.
 - Boys tend to be more adversely affected than girls and recover more slowly.
 - Children have more trouble adjusting if the parents cannot control their anger and argue in front of the children.
 - Children are affected negatively if the custodial parent has financial difficulties.
 - Children are affected negatively if positive relationships with both parents are not continued.
 - Current research shows that a stable single-parent or step-parent family is more beneficial than an intact family in conflict.
2. Remarriage is almost as stressful as divorce.
 - Remarriage rates within three to five years: 75 percent of divorced mothers
80 percent of divorced fathers
 - Older children will have a longer recovery time with remarriage than divorce.
 - Girls seem to be more reluctant to accept a step-father.
 - Preadolescent boys seem to benefit from having a step-father.

VI. Age-Related Patterns of Development

While differentiating the details of development is left to infant and child development specialists, common patterns of physical, social and emotional, and intellectual development are readily observable. The following lists are not complete and are not intended for diagnostic purposes. They are instead meant to convey the general progression of development and to **demonstrate that one level of development or skill lays the foundation for the next higher level of development or skill.**

(For Letters A-K below, Read/Study Through only One Time)

A. Birth to 4 Months

1. Physical Development

- Weight: 10-18 pounds; length: 23-27 inches
- Averages 14-17 hours of sleep daily
- Sleeps about 6 hours at a time during the night
- Lifts head and chest when lying on stomach
- Lifts head when held to shoulder
- Eyes follow moving object or person
- Grasps rattle or finger
- Wiggles and kicks with arms and legs

2. Social and Emotional Development

- Loves to be touched and held closely
- Anticipates being lifted
- Communicates hunger, fear, discomfort (through crying or facial expressions)
- Babbles, coos, and gurgles
- Responds to a shaking bell or rattle
- Returns a smile
- Responds to peek-a-boo games

3. Intellectual Development

- Recognizes bottle or breast
- Change of expressions is noticeable at sound of mother's voice
- Explores with fingers, hands, and toes
- Turns head toward bright lights and colors
- Explores objects with mouth

B. 5 to 8 Months

1. Physical Development

- Weight: 14-23 pounds; length: 25-30 inches
- Appearance of first teeth
- True eye color is established
- Hair growth begins to cover the head
- Drools, mouths, and chews on objects
- Needs a minimum of 3 to 4 feedings every day
- Purposeful grabbing and reaching at objects; reaches for cup or spoon when being fed
- Drinks from a cup with help
- Enjoys some finely-chopped solid foods
- Closes mouth firmly or turns head away when no longer hungry
- May sleep 11-13 hours at night (varies greatly)
- Naps 2 to 3 times during the day
- Develops a rhythm for feeding, eliminating, sleeping, and being awake
- Rolls over
- Bounces when held in a standing position
- Sits alone without support and holds head erect
- Raises up and rocks in crawling position but may not move forward
- Uses finger and thumb to pick up an object
- Transfers objects from one hand to the other

2. Social and Emotional Development

- Responds to own name
- Shows fear of falling from high places
- Differentiates between strangers and family
- Spends a lot of time watching and observing
- Imitates sounds, actions, facial expressions of others
- Smiles and pats at own reflection in mirror
- Squeals, laughs, babbles, smiles in response
- Raises arms as a “hold me” sign
- Recognizes names of family members
- Likes to be tickled and touched
- Responds joyfully to playing with others
- Does not want mother to leave
- Responds to distress of others by showing distress or crying

3. Intellectual Development

- Differentiates crying to indicate hunger, wetness, pain, etc.
- “Voices” displeasure or satisfaction
- Recognizes and looks for familiar voices and sounds
- Focuses eyes on small objects and reaches for them
- Looks for ball rolled out of sight; searches for hidden toys
- Babbles expressively as if talking
- Enjoys dropping objects over edge of chair or crib

C. 9 to 12 Months

1. Physical Development

- Weight: 17-27 pounds; length: 27-32 inches
- Sleeps 11-13 hours at night
- Some babies will stop taking a morning nap; others will continue morning and afternoon naps
- Begins to refuse bottle or weans self from breast during day
- Needs 3 meals a day with 2 snacks in between
- Enjoys drinking from a cup
- Begins to eat finger foods
- Continues to explore everything by mouth
- Enjoys opening and closing cabinet doors
- Easily goes from sitting to crawling and from crawling to sitting; crawls well
- Pulls self to standing position
- Stands alone holding onto furniture for support
- Walks holding onto furniture or with adult help

2. Social and Emotional Development

- Imitates adult actions such as talking on a phone
- Offers toys or objects to others but expects them to be returned
- May become attached to a favorite toy or blanket
- Pushes away unwanted things and people

3. Intellectual Development

- Says first word
- Says da-da or ma-ma or equivalent
- “Dances” or bounces to music
- Interested in picture books
- Pays attention to conversations
- Claps hands, waves bye, if prompted
- Likes to place objects inside of one another

D. 12 to 18 Months

1. Physical Development

- Weight: 17-30 pounds; height: 27-35 inches
- Walks without help, crawls well, stands alone
- Naps 1-3 hours
- Gestures (points) to indicate wants
- Likes to push, pull, poke, twist, squeeze, and dump things
- Pulls off hats and socks
- Turns pages in a book; stacks blocks
- Enjoys flushing toilets and closing doors
- Carries small objects while walking, often one in each hand
- Scribbles with little control
- Waves bye-bye and claps hands
- Likes to hold spoon while eating but has trouble getting spoon into mouth
- Rolls a ball to an adult on request

2. Social and Emotional Development

- Imitates others (coughing, sneezing, animal sounds)
- Enjoys an audience and applauds
- Becomes anxious when separated from parent
- Likes to hand objects to others
- Enjoys being held and read to
- Recognizes self in mirrors or pictures
- Plays alone on floor with toys
- Curious but wary of strangers
- Begins to seek help from others

3. Intellectual Development

- Says 8 to 20 understandable words including expressions like uh-oh
- Asks specifically for mother or father
- Develops sense of “mine”
- Looks at person talking
- Identifies objects in pictures or books
- Understands and follows simple 1-step directions
- Likes to take things apart
- Uses hi, bye, and please with reminding
- Acts out familiar activities like pretending to take a bath

E. 18 to 24 Months

1. Physical Development

- Weight: 20-32 pounds; height: 30-37 inches
- Walks well; runs stiffly but cannot always stop and turn well
- Takes steps backward
- Bends over to pick up objects without falling
- Wiggles thumb
- Turns knobs (every one in sight)
- Enjoys sitting on and moving small-wheeled riding toys
- Drinks from a straw
- Feeds self with a spoon
- Helps wash hands
- Gains some control over bowels and bladder
- Can toss or roll a large ball

2. Social and Emotional Development

- A sense of independence begins; says “no”
- Has trouble sharing
- Is increasingly selfish; uses “me” and “mine”
- Is increasingly impatient; doesn’t want to wait; wants things right now!
- Displays anger and has temper tantrums; can slap or hit when frustrated
- Tries to do many things by himself or herself
- Explores surroundings; gets into everything; needs constant supervision
- Generally does not remember rules
- Will comfort an upset friend or parent
- Is shy around strangers
- Returns hugs and kisses
- Engages in simple pretend play

3. Intellectual Development

- Shows preference between toys
- Likes to choose between two objects
- Points to named body parts upon request
- Recognizes a familiar object with a part missing
- Puts some objects back in place
- Vocabulary increases to up to several hundred words
- Two and three word sentences are constructed
- Hums or tries to sing
- Listens to short rhymes or fingerplays

F. 24 to 36 Months

1. Physical Development

- Weight: 22-38 pounds; height: 32-40 inches
- Has almost a full set of teeth
- Many will be toilet trained, but not all
- Climbs and descends stairs holding onto railing
- Scribbles vigorously
- Stoops or squats
- Can jump in place
- Kicks a ball forward
- Throws a ball overhand
- Tries to catch a large ball

2. Social and Emotional Development

- Possessive of caregiver's attention; show feelings of jealousy
- Short attention span
- Interested in brushing hair and teeth and dressing
- Has a sense of humor
- Destructive when frustrated or angry
- Changing activities takes quite a bit of time
- Shy around strangers
- Plays alongside others more than with them
- Solves problems by talking instead of hitting or crying
- Knows he's a boy like daddy or she's a girl like mommy

3. Intellectual Development

- Vocabulary continues to increase
- Interested in learning how to use common items
- Repeats sequence of number words
- Recognizes a small quantity (two dogs)
- Uses two to three sentences to describe an activity
- Asks questions – Who? Why? What's that? Where in my candy?
- Nursery rhymes and songs are repeated

G. 36 to 48 Months

1. Physical Development

- Weight: 25-44 pounds; height: 34-43 inches
- Appearance becomes more adult-like (taller, thinner)
- Sleeps 10-12 hours a night; will occasionally wet bed
- Dresses self with minimal help
- Pedals a tricycle
- Can stand, balance, and hop on one foot
- Learns to use toilet independently
- Draws with arm (not small hand movements)
- Can catch a bouncing ball

2. Social and Emotional Development

- Seeks attention and approval of adults
- May show preference for one parent (often the parent of the opposite sex)
- Can follow simple directions; accepts suggestions
- Enjoys playing alone but with other children
- Enjoys hearing stories about self
- Enjoys imitating other children and adults and playing house

3. Intellectual Development

- About 80 percent of speech is understood
- Uses complete, three to five word sentences
- Uses the past tense of regular verbs (talked, picked)
- Wants to know what will happen next
- Asks direct questions – Would you.....? May I.....?
- Listens attentively to short stories and books
- Wants familiar stories told with no changes in wording
- Has a sense of now, soon, and later
- Enjoys clay and play dough
- Distinguishes common colors
- Can solve simple, concrete, real, immediate problems (if wants to)
- Can draw a circle and a square
- Able to tell simple stories from books and pictures
- Able to follow a simple series of commands – Put on your pajamas, brush your teeth, and crawl in bed

H. Four Year Olds

1. Physical Development

- Weight: 27-50 pounds; height: 37-46 inches
- Dresses self with very little assistance
- Runs, jumps, hops, and skips around obstacles with ease
- Forms recognizable shapes out of clay or play dough
- Likes to be physical – climb trees, turn somersaults, etc.
- Catches, bounces, and throws a ball easily

2. Social and Emotional Development

- Often imitates parent of the same sex during play
- Has vivid imagination and frequent imaginary playmates
- Pretending expands beyond “playing house” to other settings; enjoys role playing
- Lies sometimes to protect friends or self but doesn’t really understand the concept of lying
- Has trouble differentiating make-believe from reality
- Begins to understand danger and can become fearful
- Changes the rules of games as he or she goes along
- May be bossy but will take turns and share most of the time

3. Intellectual Development

- Understands smaller, larger, smallest, largest, same, more, on, in, under, above
- Can be taught to recognize some letters and to write own name
- Can be taught name, address, and phone number
- Understands the order of daily routines
- Adapts language to listener’s level of understanding. To Daddy: “Mommy went to the grocery store.” To baby brother: “Mommy went bye-bye.”
- Speaks in complex sentences – “I had to change the channel before I could watch it.”
- Can continue one activity for 10-15 minutes
- Able to follow unrelated directions – “Change your shirt and bring me the remote control.”
- Understands and remembers own accomplishments

I. Five Year Olds

1. Physical Development

- Weight: 31-57 pounds; height: 39-48 inches
- May begin to lose baby teeth
- Uses a fork and knife well
- Cuts on a line with scissors
- Left or right hand dominance is established
- Walks down stairs alternating feet and without using handrail
- Can skip and run on tiptoe and jump rope
- Complex body coordination skills become possible – skating, swimming, bicycle riding
- May be able to tie shoelaces
- May be able to copy simple shapes and designs

2. Social and Emotional Development

- Invents games with simple rules
- Enlists and organizes other children and toys for pretend play
- Likes to test muscular strength and motor skills but is not emotionally ready for competition
- Carries on conversations with other children and adults
- Gets attention by using “bathroom words” or swear words
- Becomes more sensitive to feelings of others; notices when another child is angry or sad
- Prefers company of just 1 or 2 children at a time
- Likes to feel grown up
- Understands and respects rules
- Enjoys collecting things
- Requires some alone time
- Can be critical of other children
- Can be embarrassed by own mistakes
- Understands relationships among people and how different families are alike or different

3. Intellectual Development

- Understands about 13,000 words
- Likes to argue and reason using words like “because”
- Understands that stories have a beginning, middle, and end
- Creates and tells stories, jokes, and riddles
- Enjoys tracing or copying letters and shapes
- Enjoys drawing pictures that represent people, animals, and objects
- Can sort by size and categories
- Is interested in cause and effect

J. Six, Seven, and Eight Year Olds

1. Physical Development

- Appearance may seem gawky with long arms and legs
- Development of permanent teeth
- Can catch small balls
- Can tie shoelaces
- Enjoys copying designs and shapes, letters and numbers
- Skilled with scissors and small tools
- Can print name

2. Social and Emotional Development

- Friends become increasingly important
- Rules and rituals are interesting
- Wants to do things right; wants to perform well
- Failure or criticism are difficult to handle
- Starts to see things from another's point of view but still mainly self-centered
- Tends to see things as black or white, right or wrong, magnificent or horrible, with very little middle ground
- Seeks a sense of security in groups, organized play and clubs

3. Intellectual Development

- Doubles speaking and listening vocabularies
- Begins to understand time and the days of the week
- Learns difference between right and left
- Interested in magic and tricks
- May reverse printed letters such as b and d
- Enjoys planning and building (a fort out of blankets)
- Reading can become a major interest
- Enjoys creating elaborate collections
- Increased problem-solving ability
- Longer attention span

K. Nine, Ten, and Eleven Year Olds

1. Physical Development

- Girls are as much as 2 years ahead of boys in physical maturity and may begin to menstruate
- Body strength and hand dexterity increase
- Coordination and reaction time improve

2. Social and Emotional Development

- Begins to understand that parents and authority figures are fallible human beings
- Rituals, rules, secret codes, and made-up languages strengthen the bonds of friendship
- Enjoys club membership
- Becomes increasingly interested in competitive sports
- Outbursts of anger are less frequent
- May belittle or defy adult authority

3. Intellectual Development

- Enjoys reading fictional stories, magazines, and how-to project books
- May be interested in discussing a future career
- Fantasizes and daydreams about the future
- May develop a special interest in a particular hobby or collection
- Direct hands-on experience is not required to understand a concept

STAGES OF ADULT DEVELOPMENT

I. Erik Erikson

Erik Erikson formulated an eight (8) stage theory of development based on the Psycho-Social Crises that individuals encounter. Erikson's complete theory is laid out in the discussion of psychoanalytic theories elsewhere in this manual.

Erikson's last three stages dealt with the adult years:

- | | |
|--|-----------------------------|
| 6. Early adulthood
(20 - 35 years) | Intimacy vs. isolation |
| 7. Middle adulthood
(35 - 65 years) | Generativity vs. stagnation |
| 8. Late adulthood
(65+ years) | Integrity vs. despair |

In **early adulthood**, the task of the individual is to learn to be intimate with others. A lack of intimacy results in isolation, depending only on oneself.

In **middle adulthood**, the individual formulates plans to leave a legacy to the next generation. Stagnation or self-absorption results when the person feels he/she has done nothing for the next generation.

In **late adulthood**, the individual evaluates whether life has been worthwhile and has, therefore, been lived with integrity.

II. George Vaillant's Expansion of Erikson's Stages

George Vaillant, adult developmentalist, suggested that two stages should be added to Erikson's model. Vaillant proposed that

- A. **Career consolidation** (23 - 35 years) should be added into Erikson's Early adulthood stage. This is the stage when a career becomes coherent and stable.
- B. **Keeping the meaning vs. rigidity** (45 – 55 years) should be added into Erikson's Middle Adulthood stage since adults during these years tend to become concerned about extracting new meaning from their lives and avoiding falling into a rigid orientation.

III. Roger Gould

Gould (1978) links stage and crisis in his **developmental transformations** approach. False assumptions (myths) are challenged and transformed at every stage.

Approximate Age	Development(s)
16 – 18	Escaping the parents' world and parental control.
18 – 22	Becoming more peer group oriented than family oriented.
22 – 28	Leaving the immediate family domain Developing independence and a commitment to career and/or children
29 – 34	Questioning identity and roles Realizing life is not simple and controllable May experience dissatisfaction in career or marriage
35 – 43	Awareness of mortality Goals are evaluated and realigned
43 – 53	One's life is accepted Realizes some things can't be changed
53 – 60	A general mellowing evolves with an increased tolerance Less negativism

IV. Daniel Levinson

Levinson (1978) interviewed middle-aged men from different backgrounds. He and his colleagues discovered that both white-collar and blue-collar men exhibited the same patterns. In his book *Seasons of a Man's Life*, Levinson outlines three major adult transitions:

- A. **Early adult transition** – occurs between 17 and 22
 - The individual's concept of his ideal adult life is conceived; decisions are made regarding college, military service, and breaking away from one's parents.
 - This transition is followed by a period of entering the adult world.
- B. **Age 30 transition** – occurs between 28 and 33
 - The individual works at making the ideal become reality; earlier decisions are evaluated.
 - After this stage, a **settling down period** commences.
- C. **Midlife transition** – occurs between 40 and 45
 - Dreams are questioned; unreached goals are acknowledged; mortality is recognized; a stressful timeframe.
 - The later periods or stages (**middle and late adulthood**) begins at age 46 and is concerned with formulating appropriate life structures for love, marriage, vocation, and family.

A "**Midlife Crisis**" may occur, usually between the ages of 35 and 45 years. Such a crisis is often triggered by external events like divorce or children leaving home. The crisis will usually be moderate to severe and will involve:

- evaluating differences between goals and accomplishments
- confronting one's limitations
- accepting the inevitability of aging and death

Levinson viewed the mid-life crisis as a **positive** experience. He believed that avoiding or bypassing the confrontation of ideals vs. reality could lead to stagnation, staleness, or a lack of vitality in later years.

V. Gail Sheehy

Sheehy interviewed men and women and concluded that people experience predictable or typical crises or difficult times which she called **passages**. Her book *Passages* describes these experiences as useful junctures on the pathway to reaching one's full potential.

Sheehy's Life Stages are:

- Pulling up Roots (ages 18-22),
- The Trying Twenties (ages 22-29),
- Catching Thirty (age 30),
- Rooting and Extending (the 30's),
- Deadline Decade (ages 34-45),
- Renewal and Resignation (the mid-40's)

VI. Alice Rossi

Rossi (1987) lays out **4 stages of adult development related to parenting**:

1. **Anticipatory**: The adjustment to pregnancy and new responsibilities.
2. **Honeymoon**: The formation of parent-child attachments; parents adapt to new family and social roles.
3. **Plateau**: The adapting of parents to the child's demands as the child passes from infancy through adolescence.
4. **Disengagement**: The child leaving home.

The happiest years of marriage are just before the first child is born and the years after children have left home.

VII. Four-Stage Cycle of Sexual Arousal

Masters & Johnson studied sexual responses in men and women for eleven years and delineated a four-stage cycle for both:

1. **Excitement Phase** – Initiated by whatever is stimulating to the person; heart, respiration, and blood pressure rates increase. Erection and engorgements occur.
2. **Plateau Phase** – The tension prepares the body for orgasm. There is increased stimulation of the body parts and functions.
3. **Orgasm Phase** – The body changes resulting from stimulation reaching maximum intensity. Muscles in female and male sexual organs contract rhythmically.
4. **Resolution Phase** – A lessening of sexual tension as the person returns to the unstimulated state.

VIII. Marriage

1. Even though the United States has tallied a divorce rate of right at 50 percent, people still want to marry. Remarriage is also an indicator of this as half of all marriages involve the remarriage of one of the partners.
2. A long-term trend toward later marriage points to the possibility of marital stability in the future (Axelson, 1999). The median age for men rose from 23 in 1970 to 27 in 1997; the median age for women rose from 20 in 1970 to 25 in 1997 (Kail & Cavanaugh, 2001).
3. Child-rearing responsibilities bring additional pressure to relationships. Juggling parenthood with the other responsibilities of life often brings a lessening of marital satisfaction. After the children begin to leave, higher levels of satisfaction can return (Santrock, 1999).

ISSUES RELATED TO THE AGING PROCESS

I. Adjustment to Aging

The first assumptions about how people age have been **proven wrong**.

These theories associated well-being in later years with either:

- the **disengagement theory** – It is normal and desirable for older people and society to mutually withdraw as disengagement helps the elderly find a state of equilibrium.
- the **activity theory** – Well-being and satisfaction are the function of activity and social engagement. When the elderly must give up active roles, they must find substitute activities (Santrock, 1999).

Current studies indicate that a person is more likely to have satisfying later years if he or she can maintain a lifestyle consistent with his or her personality type. Health and financial pressures can impede satisfaction.

II. Biology of Aging

A. Skin and hair – Skin will dry, wrinkle, and will become inelastic and thinner.

Keratinosis (hard, callous like growths on skin) develops, sweating diminishes, and hair is progressively lost.

B. Muscles – Muscle mass and strength is lost. There is an actual loss of muscle cells and a subsequent replacement by fibrous tissue.

C. Nervous system – Reflexes slow some. Recent memory is impaired. Interests narrow. Adaptability is lessened, and there is difficulty with new ideas and with possessiveness.

D. Senses – A loss of taste and smell may occur. Farsightedness occurs as well as a reduced visual field. Adaptation to darkness is slowed, and there is an increased threshold for light stimulation (It becomes hard to see in dim light.). Hearing decreases, particularly in higher frequencies.

E. Cardiovascular – Cardiovascular output is decreased at rest. There is a tendency toward increased systolic blood pressure.

F. Respiratory – Total lung capacity and vital capacity decrease. Maximal breathing capacity decreases.

G. Gastro-intestinal – A loss of motility (capacity for movement) and decreased peristalsis (involuntary contractions of the intestinal walls), along with a decrease in gastric acid and absorption of iron (anemia), are evident.

H. Urinary tract – The renal blood flow glomerular filtration rate (rate of filtration by the kidneys) decreases. Incontinence, prostatic enlargement, and bladder infections occur.

III. Realities of Aging

A. The “Age Wave”

Regarding aging, the United States is entering a period of time like none seen before.

- In 1900, only 4 percent of the population was 65 and older.
- In 2000, roughly 13 percent of the population was over 65 due to increasing longevity (human life expectancy has doubled) and the baby boom.
- By 2040, the over-65 segment will increase to 25 percent.

Within that over-65 group, the over-85 numbers present their own age-related problems due to functional limitations and to the increasing seriousness of health problems.

- In 2000, 12 percent of the over-65 population was 85 or older.
- In 2040, that percentage is expected to rise to 20 percent with an additional increase to 25 percent by 2050.

B. The Myth about Decreasing in Intelligence

- Only eight percent of the over-65 individuals are senile.
- A decrease in intellectual functioning is seen according to the theory of “terminal drop” but only in the last five years of life.
- Older individuals can and do learn new things.

C. The Myth about Decrease in Sexual Activity

- Sexual activity can be a life-long activity unless health issues interfere or the individual accepts the stereotype that old people are asexual.
- Closeness, sensuality, and being valued are life-long needs even when actual intercourse is not possible.
- Sexuality and health issues usually top the list of concerns just ahead of financial security issues and social interactions.

D. Fear of Death

- The fear of death is thought to be greatest during middle age. Erikson indicated that the finality of life is better dealt with during the last stage of life.
- Older adults consider death more than younger ones but have less anxiety.
- Kubler-Ross (1969) is famous for initiating studies of the stages people go through in accepting death and dying. She originally suggested that these were sequential steps, but later studies have shown that the order may be changed, and the steps may be repeated.

Denial and isolation
Anger
Bargaining
Depression
Acceptance

ADDITIONAL MISCELLANEOUS INFORMATION

1. **Ambidextrous** – able to use both hands with equal ease.
2. **Anxiety (or generalized anxiety)** – unexplainable apprehension, fear, or dread; the cause cannot be determined. Note that a phobia has a known source or cause (bugs, heights, elevators, etc.)
3. **Apgar rating or score** – a quantitative rating test used to measure the vital signs of newborns a minute or two after birth; a score of 7 indicates good health; a score of 4 or less indicates that there is high-risk, and medical intervention is required.
4. **Attitude** – refers to how one thinks, acts behaviorally, and feels about a given subject. Research in this area would be conducted by a social psychologist. **Festinger** is associated with the study of attitude changes. **Thurstone** first developed a scale technique to measure attitude. This scale technique was later simplified by **Likert**.
5. **Cannon-Bard or Emergency Theory** – This theory pertains to which comes first, the physical action or the emotional reaction?
 - The **Cannon-Bard** theory states that both occur simultaneously. The brain perceives the emotional stimuli at the same time that the body initiates an action.
 - The **James-Lange** theory asserts that the individual's perception of his physical reaction is the basis of his emotional experience.
 - The cognitive theory proposed by **Schachter and Singer** in 1962 is similar to the James-Lange theory in that emotion follows action. The individual will “feel” the emotion that he or she feels is most appropriate for the arousing situation.
6. **Chaining** – describes the phenomenon (in learning theory) of each response acting as the stimuli for the next response; used by behaviorists to explain complex behaviors.
7. **Cognitive Dissonance** – a non-fitting relationship between two beliefs or ideas that cause psychological discomfort.
8. **Cohort effect** – the effect of a group of people being born at a certain time and being reared in a certain historical setting, i.e. career choices of baby boomers.

9. **Communication** – broken down into two categories.
 - a. Verbal – uses words.
 - b. Non-verbal:
 - (1) Kinetics – the study of body language pioneered by Birdwhistell.
 - (2) Proxemics – the research of territorial or personal space; this was first researched by Hall.
10. **Critical Period** – the timeframe in which something must be learned if it is to be learned at all. Readiness to learn the behavior must exist, and the environment must provide the tools, stimuli, etc. For example, the critical period for language acquisition begins around the age of two and ends around age 14.
11. **Curative Factors** – have been researched in studies concerning what percentage of the population benefit from therapy.
 - **Eysenck** (Hunt, 1993) indicated that people responded equally to problem resolution whether treated, put on a waiting list, or not treated.
 - Newer research shows that clients in therapy are 80-85 percent better off than those placed on a waiting list or not treated.
 - Newer studies of various therapy/treatment modalities found no one particular model better than any other.
12. **Development** – refers to relatively enduring changes in a person's capacity and behavior as he/she grows older.
 - a. Learning – refers to relatively enduring changes in behavior that take place as the result of experience.
 - b. Maturation – refers to the unfolding of inherited biological patterns.
13. **Diagnostic and Statistical Manual of Mental Disorders (DSM)** – manual published by the American Psychiatric Association; provides a means to consistently (meaning consistency from mental health practitioner to mental health practitioner) classify and label mental disorders according to symptomatology. The DSM is the main nosological guide for counselors. (Nosology is the branch of medicine dealing with the classification of disease.)
14. **Discrimination** –
 - (1) The ability to recognize distinct features of similar, but non-identical things
 - (2) The process of distinguishing between stimuli
 - (3) In learning, the ability to withhold a behavioral response except in the presence of specific stimuli

15. **Down's Syndrome** – the classification of mental retardation that is caused by an extra chromosome; sometimes called mongolism.
16. **Drive** – the biological condition directing behavior toward a goal.
17. **Echolalia** – the automatic repetition by someone of words spoken in his or her presence, i.e. baby's babbling when the mother talks; Echolalia is also a symptom of mental disorder.
18. **EEG or Electroencephalogram** – the graphic measure of the alpha waves of the brain.
19. **Egocentrism** – Piaget's term meant that the child could not view the world from someone else's viewpoint.
20. **Ekman** – a researcher who studied the cross-cultural facial expressions of emotions.
21. **Emotions** – have been the subject of a theoretical question that focused on whether emotions are the result of physiological arousal, or if the cognitive, experiential aspect of emotions precede physiological reaction. **Lange's** theory states that emotions result from physiological arousal. **Cannon-Bard's** theory says emotions are neurological. **Schachter's** study relates them to the release of epinephrine.
22. **Encoding** – the mental process of converting external stimuli into meaningful forms (memory).
23. **Epigenetic** – means that each stage of development proceeds out of the prior stage.
24. **Escape conditioning** – the type of learning in which an organism attempts to escape an unpleasant stimulus; in operant conditioning the response is made in order to terminate the stimuli.
25. **Genotype** – the fundamental constitution of an organism in terms of its hereditary factors.
26. **Hedonism** – a person always acts in such a way as to seek pleasure and to avoid pain.
27. **Hereditary** – passed to offspring by genes; hereditary diseases include Down's syndrome, Phenylketonuria (PKU), Klinefelter's syndrome, and Turner's syndrome.
28. **Heritability** – the part of a trait that can be attributed to genetic factors.
29. **Holophrastic speech** – expressing an entire sentence or phrase in one word, like a child's command, "Juice," meaning "Give me some juice."

- 30. **Homeostasis** – the state of optimal balance brought about by internal regulatory mechanisms. Homeostasis may be physical, social, or familial.
- 31. **Identity Crisis** – Erikson felt that adolescents will experiment with various different identities in an attempt to discover who they really are.
- 32. **Insight** – a clear, sudden understanding.
- 33. **Interactionism** – a technique for studying social groups by analyzing the group members using twelve different categories.
- 34. **James-Lange Theory** – This theory pertains to which comes first, the physical action or the emotional reaction?

The **Cannon-Bard** theory states that both occur simultaneously. The brain perceives the emotional stimuli at the same time that the body initiates an action.

The **James-Lange** theory asserts that the individual's perception of his physical reaction is the basis of his emotional experience, i.e. sees lightning and hears a clap of thunder; responds internally with heightened pulse, etc.; feels fear because body is stimulated.

The cognitive theory proposed by **Schachter and Singer** in 1962 is similar to the James-Lange theory in that emotion follows action. The individual will "feel" the emotion that he or she feels is most appropriate for the arousing situation.

- 35. **Klinefelter's syndrome** – a male shows no masculinity at puberty.
- 36. **Lallation** – substitution of a sound for another sound, i.e. tuice instead of juice.
- 37. **Lamaze method** – a training program in natural childbirth, emphasizing breathing control and relaxation during labor together with the presence and encouraging assistance of the father.
- 38. **Latent Learning** – learning that takes place without an immediate manifestation.
- 39. **Learned Helplessness** – a response to prolonged stress. It is the feeling that one's actions do not affect one's environment or what happens to oneself. Learned helplessness can lead to apathy and depression. **Martin Seligman** experimentally induced learned helplessness in dogs. He gave them electric shocks while they were harnessed and could not move. When the harnesses were removed, the dogs did not try to escape the painful shocks.

40. **Locus of Control (Internal or External)** – terms of **Rotter** describing what people think about who controls life. Internal-locus-of-control people believe that they control their own behavior. In contrast, external-locus-of-control indicates a belief that external events, fate, God, or something else controls what happens.

41. **McClelland** – studied parenting techniques of high achievers:

- Mothers expected self-reliant mastery of boys.
- Parents set high standards of excellence.
- Both parents' input was important.

McClelland discovered that rigid authoritarian methods led to a lower need for achievement.

McClelland's work addressed the questions of **motivation**. He suggested that early on individuals attempt activities based on their perception of positive and negative effects. Anything that is seen as leading to a positive effect will be approached; anything leading to a negative effect will be avoided. As noted above, McClelland applied his motivational constructs to parenting outcomes. He also applied his theories to career choice decisions and predictions of the economic growth and potential of countries based on the achievement motivation of their populations.

McClelland's terminology included a desire to achieve (nAch), a desire to be recognized (nAffi), and a desire to be successful (nSu).

42. **Metaneeds** – another term for higher-order needs.

43. **Midlife Crisis** – a period of identity development which involves re-evaluating and re-choosing identity components; may occur, usually between the ages of 35 and 45 years. Such a crisis is often triggered by external events like divorce or children leaving home. The crisis will usually be moderate to severe and will involve evaluating differences between goals and accomplishments, confronting one's limitations, and accepting the inevitability of aging and death.

Levinson viewed the mid-life crisis as a positive experience. He believed that avoiding or bypassing the confrontation of ideals vs. reality could lead to stagnation, staleness, or a lack of vitality in later years.

Erikson's seventh stage of generativity vs. stagnation encompasses the midlife crisis.

44. **Moral development** – Morality has been explained by theorists in different ways:

Freud believed morality developed from the superego.

Eric Berne, the Father of Transactional Analysis, put everyday words to Freudian concepts. His parent ego state is similar to Freud's superego and contains the shoulds, oughts, and musts that frequently guide morality.

Piaget proposed two levels of moral development: Heteronomous and Autonomous

Kohlberg proposed three levels (with two stages each) of moral development:

Level One – Preconventional

- (1) Obedience and Punishment Orientation
- (2) Instrumental Relativist or Naïve Hedonism or Egotistic Orientation

Level Two – Conventional

- (1) Interpersonal Concordance Orientation
- (2) Authority, Law, and Duty Orientation

Level Three – Postconventional or Morality of Self-Accepted Principles or Personal Integrity

- (1) Social Contract Orientation
- (2) Universal Ethical Principles Orientation

45. **Motivation** – the social or psychological condition that directs one's behavior toward a certain goal.
46. **Nosology** – the branch of medicine dealing with the classification of disease.
47. **Ontogenesis** – the course of development of an organism or an individual.
48. **Opponent-Process Theory of Emotion** – **Solomon** proposed the following (1980):
- a. The conditions that arouse a motivational or an emotional state (State A) also call out a more sluggishly acting opposing state (State B).
 - b. State B is a “slave” state which occurs as an inevitable accompaniment of State A.
 - c. Termination of the original emotional circumstances leave State B as the dominant emotional state.
 - d. State B, but not State A, increases with use and decreases with disuse.

An application of opponent-process theory can be found in many situations, opiate addiction for instance:

At first the effect of the drug (State A) is a feeling of euphoria.

When the drug wears off, its aftereffect (State B) is craving.

With continued use and the strengthening of State B, the effect of the drug is less intense.

Its aftereffect is now much more intense (painful withdrawals).

49. **Phobia** – a strong, irrational fear of a specific object or situation. Note that anxiety, on the other hand, is considered more generalized and without a known cause.
50. **Physiological Psychology** – the study of the central nervous system and the brain to measure their effect on human functioning. Four common neuro-transmitters are:
- (1) Serotonin – Associated with sleep disturbances.
 - (2) Epinephrine and norepinephrine – Associated with stress reactions.
 - (3) Acetylcholine – Allows the transmission of impulses across the synapse.
 - (4) Dopamine – Affects neurons in the corpus stratum. A deficiency in this area is associated with symptoms found in Parkinson's disease. An excess of dopamine is thought to be a cause of hallucinations and other symptoms found in schizophrenia.
51. **PKU or Phenylketonuria** – an inherited form of mental retardation for which newborns are tested. PKU is due to a disorder of amino-acid metabolism. To be avoided, the child is placed on a strict diet after birth.
52. **Pre-adolescence** – the stage from 6 to 12 years of age when girls develop more rapidly than boys; the peer group and teachers become especially important in learning and social development; and the youth begins the process of diminishing family ties.
53. **Programmed instruction** – instruction using operant conditioning techniques; materials are presented in discrete units that require an immediate response from the learner; the learner then receives immediate feedback regarding his or her response.
54. **Psychodiagnosis** – the analysis and explanation of a client's problems; pertains to the study of personality through interpretation of behavior and nonverbal clues.
55. **Psychometric** – mental testing or measurement.
56. **Psychopharmacology** – studies the effects drugs have on psychological functions.
57. **Psychosis** – mental disorder in which contact with reality is impaired; includes hallucinations, delusions, and thought disorders.
58. **Public Law 94.142** – the federal government's mandate to provide a free and appropriate education for all children. A key provision of the bill is to develop individualized education programs for children with special needs. Also, each child must be instructed in the least restrictive environment. Also know IDEA – Individuals with Disabilities Education Act.

59. **Rapid Eye Movement (REM)** – the periodic, rapid, jerky movement of the eyeballs under closed lids during stages of sleep associated with dreaming. Babies experience more REM sleep than older children and adults.
60. **Reticular Activating System or RAS** – the alerting system of the brain located at the base of the brain and extending from the central core of the brain stem to all parts of the cerebral cortex. This system is essential in initiating and maintaining wakefulness and introspection and in directing attention. It screens sensations and is thought to be the area contributing to hyperactive behavior (ADHD).
61. **Retrieval** – previously acquired learning is brought forth by the memory.
62. **Rites of Passage** – a ceremony, an event, or an achievement marking a significant transition in a person's life, i. e. puberty, marriage, death, an adolescent being giving his own set of car keys.
63. **Schachter's Cognitive Theory** – This theory pertains to which comes first, the physical action or the emotional reaction?

The **Cannon-Bard** theory states that both occur simultaneously. The brain perceives the emotional stimuli at the same time that the body initiates an action.

The **James-Lange** theory asserts that the individual's perception of his physical reaction is the basis of his emotional experience.

The cognitive theory proposed by **Schachter and Singer** in 1962 is similar to the James-Lange theory in that emotion follows action. The individual will "feel" the emotion that he or she feels is most appropriate for the arousing situation.

64. **Self-fulfilling Prophecy** – the idea that one's expectations can influence or bring about that which one expects to happen.
65. **Senile psychosis** – mental disorder in which old age causes an impaired contact with reality; more loosely may refer to memory loss.
66. **Suicide** – the taking of one's own life. The majority of persons who eventually kill themselves give warning of their intent. Among adolescents and young adults, ages 15 to 24, suicide is the second leading cause of death; about 6,000 adolescents commit suicides annually. Males commit suicide three times more often than females, but females attempt suicide three times more often than males. The following are considered to be high risk characteristics: over 45 years of age; male; presence of alcoholism; violent behavior; prior suicidal behavior; previous psychiatric hospitalization.

67. **Split-Brain Theory** – the result of studies by Sperry showing that the brain has two hemispheres, right and left, with separate functions.

Left Brain Hemisphere

Physical World

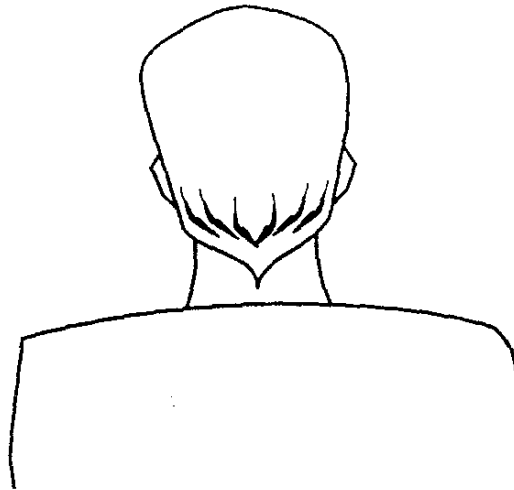
Reasoning

Mathematics

Language

Scientific Skills

Logic



Right Brain Hemisphere

Spiritual World

Imagination

Creativity

Art

Insight

Intuition

68. **Brain Lateralization Theory**- states that the right side of the brain controls the left side of the body and that the left side of the brain controls the right side of the body. (Note the difference between Split-Brain Theory and Brain Lateralization Theory.)
69. **Telegraphic speech** – utterances of two or three words that children make usually between the ages of 18 months and 24 months that convey complete thought.
70. **Transfer Learning** – the effect of earlier learning on present learning. New learning is positive if the earlier learning was positive and, therefore, is easier; a negative transfer occurs if earlier learning was hard (Example: Success or failure with math in younger years will determine how children approach math at an upper level of learning).
71. **Turner's syndrome** – a female has no gonads or sex hormones.

Orphan

Annie's

a

Pretty

Little

Girl

FREUD

- 1 Oral (0 - 2)
- 2 Anal (2 - 3)
- 3 Phallic (3 - 6)
- 4 Latency (6 - puberty)
- 5 Genital (puberty)

FREUD

- 1 Oral (birth - 2)
- 2 Anal (2 - 3)
- 3 Phallic (3 - 6)
- 4 Latency (6 - puberty)
- 5 Genital (puberty)

ERIKSON

- 1 Early infancy (0 - 1) - Basic Trust v Mistrust
- 2 Later infancy (1 - 2) - Autonomy v Shame & Doubt
- 3 Early childhood (3 -5) - Initiative v Guilt
- 4 Middle childhood (6 - 11) - Industry v Inferiority
- 5 Adolescence (12 - 20) - Identity v Role Confusion
- 6 Early adulthood (20 - 35) - Intimacy v Isolation
- 7 Middle adulthood (35 - 65) - Generativity v Stagnation
- 8 Late adulthood (65+) - Integrity v Despair

FREUD

- 1 Oral (birth - 2)
- 2 Anal (2 - 3)
- 3 Phallic (3 - 6)
- 4 Latency (6 - puberty)
- 5 Genital (puberty)

PIAGET

- Sensorimotor (0 - 2)
- Pre-operational (2 - 6)
- Concrete operational (6 - 12)
- Formal operational (12+)

MASLOW

Survival: food, water, air
Security and Safety
Love and Belonging
Esteem & Self-esteem
Self-actualization

Chapter 2

Abnormal Human Behavior

ABNORMAL HUMAN BEHAVIOR

NCE – Chapter 2

Chapter Outline

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- D. Genetic Model
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- V. Delirium, Dementia, and Amnesic and Other Cognitive Disorders
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- XVI. Sleep Disorders
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- XVIII. Adjustment Disorders
- XIX. Personality Disorders
- XX. Other Conditions Which May Be a Focus of Treatment

GLOSSARY OF TECHNICAL TERMS

ABNORMAL HUMAN BEHAVIOR

NCE – Chapter 2

PART 1 INTRODUCTORY MATERIAL

I. Four Primary Tasks

There are four primary tasks or efforts in the study of abnormal psychology, which is also referred to as psychopathology, mental illness, or behavioral disorders.

- A. **DEFINE** – means to describe or generate a clinical picture for each disorder (symptomatology), this is also called diagnosis
- B. **EXPLAIN** – means to determine or theorize about the current cause of the disorder specific to each case at this time, also called cause, etiology, or origin
- C. **PREDICT** – means to generate an anticipated course for the condition; essentially, “What will happen over time without intervention?”
- D. **CONTROL** – Having determined a need for intervention, this stage refers to intentional treatment of the condition to facilitate symptom reduction and overall recovery.

II. Models of Abnormality

The presence of abnormality, or mental illness, is typically defined from a number of conceptual positions or models. Each model defines abnormality a bit differently, emphasizing some processes and failing to address other issues.

Current thought is that each position offers advantages and disadvantages and that only by defining abnormality simultaneously from several perspectives can the clinician effectively make decisions about the presence or absence of disorder or symptoms for a specific client.

The models of abnormality can be most efficiently understood in terms of their:

- hypothesized source of abnormality (etiology)
- typical assessment strategies
- primary treatment emphases

A. Statistical Model

- Emphasizes the rarity or infrequency of a behavior or a trait as the primary determinant of mental illness. Also known as Trait Factor (Cattell, Eysenck, Zubia).
- Easily seen in the DSM-IV-TR's definition of Mental Retardation, where one of the diagnostic criteria involves achieving a score at least two standard deviations below the mean on a standardized test of intelligence.
- Focus of remediation is to establish functioning within normal levels.

B. Medical (Disease) Model

- A more general position emphasizing the similarities between medical and psychological practice.
- Much of our terminology in mental health practice is rooted in this position, including doctor, patient, illness, etiology, diagnosis, assessment, placebo, prognosis, course, treatment, and intervention.
- Criticized by some for overly emphasizing syndromes and nomenclature and failing to hold the mentally ill responsible for their problems or symptoms (e.g. "Alcoholism is a disease.").

C. Biological/Biochemical Model

- Defines the human being as an organism made up of numerous biologic and biochemical systems which are primarily responsible for determining adjustment, behavior, and disorders.
- Primary intervention methods include drugs, nutritional and environmental therapies (i.e. phototherapy for depression), ECT, and previously, psychosurgical techniques.

D. Genetic Model

1. Asks how heredity affects, causes, or predisposes one to certain disorders, and it uses experimental procedures referred to as family, twin, adoption, and genetic history studies.
2. Important terms are:
 - a. **penetrance** – the genetic transfer of mental illness or other characteristics from one generation to another
 - b. **concordance** – parallel levels of symptoms across family members
 - c. **incidence** – number of new cases
 - d. **prevalence** – number of existing cases at a point in time
3. Genetic screening and abortion are the primary modes of prevention/intervention.

E. Psychodynamic (Psychoanalytic) Model

- Explains abnormality in terms of internal (intrapsychic, unconscious) dynamics at work within the individual.
- Personality is described in terms of id, ego, and superego, and psychological maladjustment is seen as a dysfunction of defense mechanisms.
- Psychotherapy is called insight-oriented as the focus is on bringing unconscious conflicts to conscious awareness and working through these fixations and regressions through the therapeutic relationship (Freud, Jung, Horney).

F. Behavioral (Learning Theory) Model

- Applies the laws of learning, motivation, and conditioning to explain abnormality in terms of behavioral excesses and deficits.
- All disorders are viewed as a product of maladaptive learning, with processes of reinforcement, extinction, and counterconditioning used to modify behavior patterns (Pavlov, Watson, Skinner, Thorndike, Rotter, Dollard & Miller).
- Later expanded to include social learning theory (Bandura) which emphasized modeling and learning by observation.

G. Cognitive-Behavioral Model

- Similar to the behavioral position, the cognitive-behavioral position emphasizes the role of mental factors to explain abnormality, primarily through cognitive distortions (Beck) or irrational thinking (Ellis).
- Maladaptive thinking is seen as a lens through which the individual with psychological symptoms (primarily anxiety and depression) selectively interprets events to confirm his/her distorted outlook on life, the world, and the future.
- Interventions aim to modify thinking through cognitive restructuring and rational arguing.

H. Humanistic/Client-Centered Model

- Abnormality is hypothesized to result when one is not treated or loved unconditionally, resulting in a failure to fully grow and self-actualize.
- Interventions are typically non-directive, assuming that the client possesses answers to their own problems or questions which will surface in the context of a warm, supportive, empathic relationship (Maslow, Rogers).

I. Existential Models

- Emphasize the role of personal meaning and coming to term with one's inevitable death.
- The person exists in process, making free choices, and, thereby, achieving identity (Frankl, May, Kierkegaard).

J. Systemic Model

- Argues that disorders occur in systems (e.g. the family) rather than in individuals. Emphasizes concepts of homeostasis, individual roles within systems, and poor communication patterns.
- Therapy is generally preferred in the form of a group intervention (marital or family therapy).

K. Diathesis-Stress Model

- Emphasizes the combination of nature (biology and genetics) and nurture (the environment) to produce abnormality.
- A person is predisposed to a particular disorder to a certain degree but develops clinical symptoms only when he/she encounters sufficient environmental stress to exceed his/her unique threshold.
- Little direct therapeutic application, although the study of individuals at high-risk, prevention, and epidemiology are direct offshoots of this position (Selye).

III. Criteria for Evaluating Classification Systems

Blashfield and Draguns, in the *Journal of Abnormal Psychology* (1976), argued that classification systems of abnormality could be effectively judged on the basis of their:

- reliability
- coverage
- descriptive validity
- predictive validity

Their argument and many other critiques were significant voices for the vast changes which were implemented beginning with the third edition of the DSM (Diagnostic and Statistical Manual of Mental Disorders). The DSM-IV greatly improved the usefulness, accuracy, and empirical evaluation of psychiatric classification in the United States.

IV. History of Psychopathology

A. Early History

1. Stone Age

- Drawings provide the earliest evidence of the understanding and the treatment of abnormal behavior.
- The practice of “trephining,” an “operation” performed by the medicine man, consisted of chipping a circular hole in an area of the skull (a “trephine”) which was believed to allow the evil spirit who was causing all the trouble to escape.

2. Ancient Egyptian

- Writings from the 16th century B.C. provide some of the earliest written evidence of treatment of disease and behavior disorders, including a detailed description of the treatment of wounds and other surgical operations.
- These writings imply that the brain is the recognized site of mental functions.

3. Other early references

- Ancient writings of the Chinese, Egyptians, Hebrews, and Greeks show that, in general, a behavior or disorder was attributed to a demon or a spiritual force who had taken possession of the person.
- The decision as to whether the "possession" involved good spirits or evil spirits usually depended on the individual's symptoms.
- The primary type of treatment for possession was exorcism, which widely varied but in general consisted of magic, prayer, incantation, noisemaking, and the use of foul-tasting concoctions.

B. Greek and Roman Influences

1. The Height of Greek and Roman influence from the 4th century B. C. through the 3rd century A. D. led to a more physical, materialistic view of the causes and nature of abnormality as well as the treatment of medical and mental disorders.

2. Hippocrates

Hippocrates' emphasis on natural causes, clinical observations, and brain pathology as a cause of mental disorders was revolutionary.

- a. He denied that disorders were caused by the gods and argued instead that mental illness had natural and physical causes; therefore, they required treatment just like other (medical) diseases.
- b. He suggested that mental disorders were due to abnormality within the brain and listed three general categories of mental conditions, known to us and still recognized today as mania, melancholia, and phrenitis.
- c. He heavily emphasized the importance of clinical observation in cataloging a patient's symptoms. His descriptions and methods of treatment were vastly superior to the mystical practices present in his day.
- d. Hysteria was restricted to women and was caused by the wandering of the uterus to various parts of the body.
- e. Four bodily humors - blood, black bile, yellow bile, and phlegm. When the humors were adversely mixed or otherwise disturbed, physical or mental disease resulted. Although this is rejected, the emphasis on the importance of bodily balances to mental health is paralleled in our time.

3. Plato

- a. Plato studied mentally disturbed individuals who committed criminal acts and decided that they were not responsible for their acts and should not receive punishment in the same way as normal persons.
- b. He argued that mental illness should be cared for in the community as follows: "If anyone is insane, let him not be seen openly in the city, but let the relatives of such a person watch over him in the best manner they know of, and if they are negligent, let them pay a fine...."
- c. He emphasized the importance of individual differences in intellectual and other abilities.

4. Aristotle
 - a. Aristotle's most lasting contributions to psychology are his descriptions of the content of consciousness.
 - b. He conceptualized thinking as directed striving toward elimination of pain and attainment of pleasure.
5. Later Greek and Roman figures
 - a. Temples dedicated to Saturn were first-rate sanatoriums. Pleasant surroundings were considered of great therapeutic value for the mental patients, who were provided with constant activities.
 - b. Asclepiades was the first to note the difference between acute and chronic mental disorders and to distinguish between illusions, delusions, and hallucinations.
 - c. Cicero was the first to go on record as stating boldly that body ailments could be the result of emotional factors.
 - d. Aretaeus saw certain mental disorders as merely an extension of normal psychological processes. He was the first to describe the various phases of mania and melancholia and to consider these two pathological states as expressions of the same illness.
 - e. Galen made a number of original contributions concerning the anatomy of the nervous system. He maintained a scientific approach, dividing the causes of mental disorders into physical and mental. Among the causes he named were injuries to the head, alcoholic excess, shock, fear, adolescence, menstrual changes, economic reverses, and disappointment in love.
6. At the end of the period of high Greek and Roman influence a "Dark Ages" in the history of abnormal psychology began similar to that seen in the basic sciences and medicine.
 - Many of the contributions of this period were apparently "lost" as most physicians returned to a belief in mysticism and demonology as a primary causal factor in mental illness.
 - Despite this trend in the European continent, in other locations, the material/physical positions emphasized by the Greek and Roman philosophers continued to have significant influence.

C. Scientific Decline During the Middle Ages

1. During the Middle Ages, the role of scientific questioning into the cause and treatment of mental illness was limited, primarily focusing on ritual and superstition. This left a relative deficit in terms of scientific thinking and humane treatment of the mentally ill.
2. In place of physical explanation, supernatural and religious explanations of the cause of mental illness grew, and, at times, it seems that mental illness was directly attributed to an individual's poor choices or "sin" rather than simply demon possession.
3. This is also the time of mass madness, in which whole groups or communities of people appeared to be simultaneously affected, presenting symptoms of uninhibited behavior, promiscuity, and assorted other features (e.g. tarantism - supposedly due to being bitten by Tarantulas and lycanthropy - where people believed they were possessed by wolves and imitated their behavior).
4. Exorcism seems to have been the predominant form of treatment, which was most often left to the priests. It appears that the monasteries often served as places of confinement and refuge, isolating the mentally ill person from the community. Interestingly, these forms of intervention were described as "highly successful" in writings of the time.
5. One interesting question from the end of the Dark Age period has to do with the suggestion that the famous witch trials in England and the continental U.S. of the 17th and 18th centuries were possibly the result of many mentally disturbed people being accused of witchcraft, resulting in them being punished and sometimes even killed. Possessed individuals were believed to have made a pact with the devil and were tortured and severely questioned, often leading to their confession. However, although mental illness remains a possibility for explaining some of these cases, a careful review of the written record from this time does not seem to indicate that this was most often the case. According to Schoenman, who researched this question thoroughly, "the typical accused witch was not a mentally ill person but an impoverished woman with a sharp tongue and a bad temper." Thus, it appears that being a social misfit may have had more to do with the suspicion of witchcraft than did mental illness in the majority of cases.
6. Eventually, supernatural and mystical explanations of events in human experience began to give way to the more empirical and material thinking of the Enlightenment and Renaissance. This was the time of a resurgence of scientific questioning in Europe and in the U.S. Several important figures rejected demonology and offered other explanations for abnormal behavior, such as astral and bodily magnetism (Mesmer). Additionally, these figures directly challenged the Catholic Church's position (Johann Weyer).

D. Establishment of Early Asylums

From the 16th century on, the care of persons suffering from mental disorders gradually became the task of special institutions.

1. The early asylums were primary modifications of penal institutions, such as the section of the Pennsylvania Hospital, completed under the guidance of Benjamin Franklin in 1756, which provided a few cells or beds for mental patients.
2. The first U.S. hospital exclusively devoted to mental health patients was the Public Hospital located in Philadelphia. The basic intervention method emphasized that patients needed to choose reason over insanity. Treatment techniques were powerful and aggressive and were intended to restore balance between body and brain.
3. Other treatments of the time included generous use of restraints, drugs, water treatments, bleeding and blistering, and electric shock. Patients were also bled in order to drain their system of "harmful" fluids.

E. Humanitarian Reform

By the late 1700's, most mental hospitals in Europe and in America were in need of reform, functioning more as prisons or warehouses for the mentally ill instead of centers for intervention and recovery. The more humane treatment of mental patients was led by Philippe Pinel in France, William Tuke in England, and Benjamin Rush and Dorothea Dix in the U. S.

1. In 1792, Pinel was put in charge of La Bicetre, a hospital for the insane in Paris. He asked for and was given hesitant permission to release patients from their chains and dungeon-like cells to test his belief that they should be treated with kindness and consideration. Patients were instead kept in sunny rooms and were provided opportunities to exercise and to participate in social activities. Not surprisingly, these changes led to an almost miraculous level of recovery.
2. William Tuke was an English Quaker who founded the York Retreat which was a type of community home in a gentle country setting where patients lived, worked, and rested in a kind and spiritual atmosphere. Tuke also reported dramatic results.
3. In the U. S., the success of the efforts of Pinel and Tuke were noted and fostered more humanitarian methods which revolutionized the treatment of mental patients throughout the civilized world. The champion of this movement in the U. S. was Benjamin Rush, who is considered to be the founder of psychiatry in America. In the moral treatment movement which followed, mental patients were seen as normal people who had lost their way as a result of exposure to severe stressors. Moral treatment aimed at relieving the patient by social contact, talking about symptoms and difficulties in living, and involvement in purposeful activity; these strategies parallel intervention efforts today.

F. Mental Hygiene Movement

- Advances in medical science regarding infectious processes and neurological impairment had provided direct explanation for abnormality in the mid-1800's.
- This led many to abandon the humane treatment of mental patients in search of physical or biological explanations for all forms of abnormality. Unfortunately, these successes in medicine led to reduced attention to the condition of mental patients, such that by the mid-1800's psychiatric facilities in the U. S. were again characterized by neglect and mistreatment.
- Dorothea Dix was a New England schoolteacher who taught in a women's prison and was appalled by the conditions she observed there. She spent most of her career in a zealous campaign that aroused the public and produced legislation to limit inhumane treatment of the mentally ill.
- By the end of the 19th century, the mental hospital or asylum had become a familiar landmark in America. In it, mental patients lived under semi-adequate conditions of comfort and freedom from abuse. To the general public, however, the asylum remained a rather eerie place until well into the 20th century.

G. Recent History

- In 1896, Lightner Witmer founded the first psychological clinic in the U.S. in Philadelphia where he focused on addressing the problems of mentally deficient children.
- Soon psychological labs and clinics were growing in many communities and a great deal of research on abnormality was being generated. This information was disseminated through professional journals, meetings, and scientific organizations.
- By the 1940's, Clinical Psychology had arisen as a specialization within psychology focusing on research, theoretical discovery, and treatment of mental illness.
- The last half of the 20th century saw increased attention to empirical evaluation of intervention effects, increased reliance on pharmacologic treatments (drugs), and a vast increase in the number of professions dedicated to the treatment of mentally ill individuals.

H. A Final Question

What can we learn about theory, science, and clinical interventions in mental health fields today from the study of the history of abnormality? The answer lies in several observations about our review of this history.

- First, a number of obstacles may make it difficult for us to get and keep an accurate picture of the attitudes and behaviors of people who lived hundreds of years ago.
- Secondly, we cannot rely on direct observation in reviewing history; instead, we must utilize written documents from the times in question and are, therefore, restricted in our conclusions by the sources available and the biases of their authors.
- Thirdly, it is clear that even though the history of human perspectives on abnormality from ancient times to the present has not followed a straight evolutionary path, we can trace a general movement away from superstitious and "magical" explanations of abnormal behavior and toward reasoned scientific explanations.

This understanding should provide us with a humble perspective for the ideas we currently hold as certain and should encourage us to pursue recent advances and future efforts to better understand and assist mentally ill individuals.

PART 2

THE DSM-IV-TR

I. Introduction

(See pages xxiii-xxxv in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages xv-xxv]

A. Goals Guiding Development of the DSM-IV

The DSM describes three goals which guided development of the current edition of the manual.

These are that it:

1. focus on clinical, research, and educational purposes and be supported by empirical evidence
2. provide a helpful guide for clinical practice
3. facilitate research and improve communication among clinicians and researchers

B. Major Innovation

According to the authors, the major innovation in the DSM-IV was the process by which it was constructed and documented. The authors claim that it is “grounded in empirical evidence” more than any other classification system of abnormality.

C. Definition of Mental Disorder

- The definition of a mental disorder presented in the Introduction to the DSM-IV conceptualizes a disorder as a clinically-significant behavioral or psychological syndrome or pattern that occurs in an individual and is associated with distress, disability, or an increased risk of suffering.
- It further specifies that the pattern of behavior must not be simply an expected or culturally-sanctioned reaction and must represent an impairment in social or occupational functioning.
- This implies that the violation of social rules in the forms of deviant behavior or conflicts with society do not, in themselves, represent a sufficient basis for determining the presence of abnormality.

D. Limitations of a Categorical Approach

- The Introduction of the DSM-IV-TR describes several limitations of the categorical approach to classification which is utilized in the DSM.
- The most important of these limitations is a categorical model that requires distinct boundaries between conditions and homogeneity within the category.
- The DSM is admittedly weak in both of these areas as distinct boundaries between conditions are not apparent and many individuals described as having the same disorder are unlike in important ways.

E. Ethnic and Cultural Considerations

The introduction of the DSM describes several strategies utilized to assist with multicultural use of the manual.

It specifically notes:

- the presence of text discussing cultural variations in the clinical presentations of those disorders included in the DSM-IV
- the mention of culture bound syndromes that have not been included in the DSM-IV classification in an appendix
- an outline for cultural analysis which is supposedly designed to assist the clinician to systematically evaluate and report on the impact of the individual's cultural and ethnic context on their clinical presentation

II. Use of the Manual

(See pages 1-12 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 1-11]

A. Principal Diagnosis

- Clinicians indicate the principal diagnosis in DSM-IV by listing it first if it is on Axis I, which takes precedence unless otherwise noted.
- The remaining disorders are listed in order of focus of attention and treatment.
- When a person has both an Axis I and an Axis II diagnosis, the principal diagnosis or reason for the visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by a qualifying phrase (“Principal Diagnosis” or “Reason for Visit”).

B. Provisional Diagnosis

- A provisional diagnosis implies that there is enough information to make a “working” diagnosis but that the clinician wishes to indicate a certain degree a diagnostic uncertainty.
- Provisional implies a strong presumption that criteria will be met at some point in the near future either through obtaining a more specific, detailed history or through the simple passage of time.

III. Multiaxial Assessment

(See pages 27-37 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 25-35]

Multiaxial Organization

Dating from the third edition of the DSM (1980), the manual presents a multiaxial format for classifying the symptoms an individual presents and for estimating his/her unique stressors and level of functioning as follows:

Axis I	Clinical Disorders Other conditions that may be a focus of clinical attention
Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and environmental problems
Axis V	Global Assessment of Functioning

IV. Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

(See pages 39-133 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 37-121]

A. Mental Retardation

According to the DSM-IV-TR, the three diagnostic criteria for mental retardation are:

1. An I.Q. of two standard deviations below the mean (less than 70) based on a standardized, individually-administered intelligence test
2. Parallel deficits being present in adaptive functioning (2 or more skill areas)
3. Onset before age 18

		<u>IQ Score</u>	
MILD	-2 σ	50-70	Educable
MODERATE	-3 σ	35-55	Trainable
SEVERE	-4 σ	20-40	
PROFOUND	-5 σ	Below 20	

B. Criteria for Autism

The best known of the Pervasive Developmental Disorders is Autism which is conceptualized in terms of three categories of symptoms:

1. impairment in social interaction
2. impairment in communication
3. restricted, repetitive, or stereotyped patterns of behavior

C. Other Pervasive Developmental Disorders

- The three other Pervasive Developmental Disorders are Asperger's Disorder, Rett's Disorder, and Childhood Disintegrative Disorder.
- Each is Similar to Autism and should be distinguished by careful review of the clinical symptoms and developmental history of the client.

D. Learning Disability

- The DSM-IV-TR defines the presence of learning disability as an individual's achievement on an individually administered, standardized test of reading, math, or writing being substantially below that expected for age, schooling, and level of intelligence. Further, the DSM states that "substantially below" implies a discrepancy of more than two standard deviations between achievement and I.Q.
- What appears to be unworkable about this definition is that two standard deviations is too long of a time to wait. For instance, one could not diagnose a learning disability until the 3rd grade, preventing early identification and remediation of deficits during the Kindergarten, First, and Second grade years. The Education Boards of most states have adopted a more reasonable criteria.

E. Attention Deficit-Hyperactivity Disorder

As presented in the DSM-IV, the three classes of symptoms used to evaluate the presence of Attention Deficit-Hyperactivity Disorder are:

- Inattentiveness
- Hyperactivity
- Impulsivity

These symptoms are to be evident prior to age 7 and are to be demonstrated in three different contexts (environmental settings):

- at home
- at school
- with peers

F. Oppositional Defiant Disorder and Conduct Disorder

The criteria for Oppositional Defiant Disorder are similar to those described in the DSM-IV for Conduct Disorder but differ in that although ODD does include some of the features observed in CD (e.g. disobedience and opposition to authority figures), it does **not** include the persistent pattern of more serious forms of behavior in which either the basic rights of others or age-appropriate societal norms or rules are violated.

V. Delirium, Dementia, and Amnesic and Other Cognitive Disorders

(See pages 135-180 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 123-163]

A. DELIRIUM AND DEMENTIA

Distinguishing between delirium and dementia can be difficult. Accurate differential diagnosis of these conditions is best accomplished through the examination of:

- classic symptomatology
- the rate of onset
- clinical prognosis or course

	Onset	Course	Symptomatology
Delirium	rapid	reversible	•perceptual distortions •disrupted attentional impairment •disoriented
Dementia	gradual, subtle, insidious	degenerative progressive or stable	•multiple cognitive impairments •primary disturbance of memory

B. ETIOLOGY (CAUSE)

The cognitive and medical disorder categories differ from the other categories of psychiatric disturbance listed in DSM-IV in that the cause is known and is used in the name of the condition (for example, “Dementia due to Head Trauma” or “Delirium due to Substance Toxicity”).

VI. Mental Disorders Due to a General Medical Condition

(See pages 181-190 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 165-174]

As the title implies, this section discusses the (complexity of) diagnosing mental disorders due to a general medical condition. Complex because a general medical condition may be the full cause, only a part of the cause, or not part of the cause of a mental disorder. Making such a determination is crucial for determining treatment regimens. Since there is a sharing or mimicking of signs and symptoms of several disorders, the TR lists those in the various specific sections. For instance, Mood Disorder Due to a General Medical Condition is described in the Mood Disorders section of the manual.

The three disorders delineated in this chapter are:

1. Catatonic Disorder Due to a General Medical Condition
2. Personality Change Due to a General Medical Condition
3. Mental Disorder Not Otherwise Specified Due to a General Medical Condition.

VII. Substance-Related Disorders

(See pages 191-295 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 174-272]

A. Patterns of Substance Use

1. Note that the DSM-IV does not consider use of a substance to represent a psychiatric disorder in and of itself, even if that substance is illegal or dangerous.
2. The DSM-IV specifies two primary types of substance-use disorders:
 - substance abuse
 - substance dependence
3. **Substance Abuse** has historically referred to a condition in which one continues to use a substance despite knowing that it is harmful for him/her in some way.
4. **Substance Dependence** adds the requirement of accompanied tolerance and/or withdrawal symptoms.

B. Polysubstance Dependence

- According to the DSM-IV, this is a condition in which a client's use of multiple substances represents a pattern of dependence, although his/her use of any specific substance does not appear to meet the criteria for a psychiatric disorder through the term Polysubstance Dependence.
- There is no "Polysubstance Abuse" parallel category.

C. Classified Substances

The substances that are classified:

1. Alcohol
2. Opiates
3. Cannabis
4. Inhalants
5. PCP
6. Nicotine
7. Cocaine
8. Hallucinogens
9. Amphetamines (or other sympathomimetics)
10. Sedatives, Hypnotics, or Anxiolytics
11. Caffeine

Which of these causes a person to become most violently acting?

If (PCP) was removed as an option, which of the remaining would cause a person to become most violent? (Amphetamines)

D. Addiction – Know that there are two forms:

1. **Physical Addiction** refers to a drug-produced condition characterized by both tolerance and dependence.

Tolerance refers to the need for ever increasingly larger doses of a drug to obtain the initial effect of the original dose.

Dependence refers to the need for continued or repeated use of a drug in order to maintain a particular desired state which includes the avoidance of withdrawal.

2. **Psychological Addiction** refers to a pattern of behaviors wherein one is driven to use the drug and to act in ways that guarantee its availability.

Be familiar with what each is and which one is longest lasting (psychological).

E. Complications of Alcoholism

1. High rate of marital separation and divorce.
2. Job troubles including frequent absenteeism and job loss.
3. High frequency of accidents - in the home, on the job, and while driving. About 40 percent of highway fatalities in the U.S. involve a driver who has been drinking.
4. Nearly half of convicted felons are alcoholics.

5. About half of police activities in large cities are associated with alcohol-related offenses.

F. Theories of Drug Use and Abuse

1. Disease-Addiction Theory – Perceives drug use as an aberrant phenomenon afflicting otherwise healthy people. The exposure and use of the drug, with its addictive potential is the reason for the abuse. This disease model is central to medical treatment of drug abuse.
2. Gateway Theory – Emphasizes the orderly progression from one drug to another as young people get more involved in drug use. This is also called the stepping-stone theory.
3. Social Theories – Specify how features of the social structure that are external to an individual produce observable patterns of drug-using behavior.
4. Psychological Theories – Examine the individual's personality and psychopathology to explain drug abuse as a maladaptive behavior.
5. Political Theory – Believes that each individual has the right to use drugs as he/she sees fit and that society should have a hands-off policy.
6. Psycho-Social Theories – Suggests that an individual's personality, environment, and behavior are inter-related and organized so as to develop a dynamic state designated as "problem-behavior proneness."
7. Life-Style Theories – Point out that groups of adolescent drug-users share unique and identifiable characteristics. Drugs are linked to other activities and play an important part in defining a group, both to its members and to outsiders.
8. Peer Cluster Theory – Suggests that small, identifiable peer clusters determine where, when, and how drugs will be used.

VIII. Schizophrenia and Other Psychotic Disorders

(See pages 297-343 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 273-315]

A. Schizophrenia

- One of the most debilitating and significant conditions of mental illness, schizophrenia involves a qualitative impairment in functioning, including in the most severe conditions a loss of contact with reality.
- The DSM-IV lists five specific diagnostic criteria for schizophrenia, the most prominent of which are delusions (which are beliefs held despite overwhelming evidence that they are untrue) and hallucinations (which are sensory misperceptions of reality).
- Hallucinations and delusions are considered to be positive symptoms, implying that they are excesses and do not occur among normals. Other positive symptoms involve disorganization of speech or behavior.
- Negative symptoms represent deficits in comparison to the functioning of individuals without schizophrenia and specifically involve avolition, anhedonia, amotivation, alogia, and flat affect. These are more prominent during the latter or residual phase of a schizophrenic episode.
 - Avolition – without will; no desires
 - Anhedonia – not able to enjoy normally enjoyable experiences
 - Amotivation – without a drive for achievement
 - Alogia – diminished thinking ability

(See Glossary of DSM-IV for more thorough explanations)

B. Subtypes of Schizophrenia

In addition to the Residual type of Schizophrenia, in which the patient no longer meets the full criteria for diagnosis, there are four other subtypes described in the DSM-IV:

1. Paranoid Schizophrenia involves an organized delusional system or theme such as persecution.
2. Disorganized Schizophrenia involves a primary disturbance of self-care habits or language.
3. Catatonic Schizophrenia involves a primary disruption of motor functioning, either to excess (agitated movement) or to near-paralysis (catatonia).
4. Undifferentiated Schizophrenia is the sub-type in which the clinician is unable to successfully classify the patient's symptoms into any of the preceding subtype descriptions.

C. Related Disorders

1. Brief Psychotic Disorder is similar to schizophrenia, but the duration is less than one month.
2. Schizophreniform Disorder also replicates the Schizophrenia criteria but covers a duration of symptom presence between one and six months.
3. Delusional Disorder involves exclusive psychotic symptoms of delusions, but these are differentiated from Schizophrenia by being labeled “nonbizarre.”
4. Schizoaffective Disorder involves the simultaneous presentation of a Schizophrenic and a Mood Disorder.
5. Schizotypal Personality Disorder involves many of the odd and eccentric characteristics of Schizophrenia without presentation of the major clinical criteria (hallucinations, delusions, or gross disorganization).

IX. Mood Disorders

(See pages 345-428 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 317-391]

A. Mood Disorders with Overly Positive Periods

There are three major categories of Mood Disorders which involve periods of overly elevated mood:

- Bipolar I
- Bipolar II
- Cyclothymia
 1. **Bipolar I** is characterized by one or more Manic or Mixed Episodes, usually accompanied by alternating Major Depressive Episodes.
 2. **Bipolar II** is characterized by one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode (but no episodes meeting the criteria for full-blown mania).
 3. **Cyclothymia** is characterized by at least two years of numerous periods of hypomanic symptoms that do not meet criteria for a Manic Episode and numerous periods of depressive symptoms that do not meet criteria for a Major Depressive Episode.
- The major criteria for a **manic episode** are:
 1. Inflated self-esteem or grandiosity
 2. Decreased need for sleep
 3. More talkativeness than usual or pressure to keep talking
 4. Flight of ideas or subjective experience that thoughts are racing
 5. Distractibility
 6. Increase in goal-directed activity
 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences

B. Mood Disorders with Exclusively Negative Episodes

- Major Depressive Disorder and Dysthymia are the terms used in the DSM-IV to describe negative mood or depressed conditions.
- Major Depressive Disorder is characterized by one or more Major Depressive Episodes (i.e., at least two weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression).
- Dysthymia is characterized by at least two years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive Episode.

C. Important Considerations

When interviewing depressed patients, several important details must be questioned, as these conditions may mimic or significantly exacerbate a depressive condition.

The three primary issues to consider are a:

1. Review of clinical information that focuses on the symptoms during the worst part of the current episode
2. Review for general medical conditions, including possible diabetic and thyroid problems
3. Review for mood-incongruent delusions or hallucinations and a history of any manic periods

D. Indicators of Depressive Severity

The three characteristic behavior changes which signify a severe depressive reaction are:

1. a markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
2. significant weight loss, when not dieting, or weight gain, or decrease or increase in appetite nearly every day
3. insomnia or hypersomnia nearly every day

These physiologic or “vegetative” symptoms are believed to represent the most significant need for referral for medication.

X. Anxiety Disorders

(See pages 429-484 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 393-444]

A. Normal Anxiety vs. Clinical Disorders

- Normal anxiety differs from clinical-levels of impairment in terms of the intensity, duration, and/or frequency of the anxiety and the worry.
- Also, the fear is experienced in excess of the actual likelihood or impact of the feared event.
- The clinically-anxious individual will also find it difficult to keep worrisome thoughts from interfering with attention to tasks at hand and has difficulty stopping the worry.

B. The Role of Specific Stimuli in Anxiety Disorder Treatment

Behavioral strategies for treating anxiety disorders in general and for phobias in particular involve two basic components:

- exposure (confrontation) of the feared stimulus
- prevention of the escape (or avoidance) response

Behavioral treatments for these conditions have been highly successful and are generally preferred over medication and other alternatives. However, the clinician must have a clear and specific stimulus to expose the individual to; thus, these interventions are not as applicable to anxiety disorders without clear and specific fear stimuli, such as Generalized Anxiety Disorder and Panic Disorder.

C. Panic Attacks and Differential Diagnosis

- The primary symptoms of a panic attack are palpitations, pounding heart, accelerated heart rate, sweating, shaking or trembling, and sensations of shortness of breath or smothering.
- Not surprisingly then, panic attacks are often mistaken for heart attacks, and medical assessment of cardiovascular status should be completed before beginning a psychologically-based intervention for panic symptoms.

XI. Somatoform Disorders

(See pages 485-511 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 445-469]

A. Common Feature of Somatoform Disorders

The common feature of the somatoform disorders is the presence of physical symptoms that suggest a general medical condition and are not adequately or fully explained by a general medical condition, the direct effects of a substance, or another mental disorder.

B. Types of Somatoform Disorders

The DSM-IV lists six specific Somatoform Disorders. Specific criteria for each condition are given in the manual. The six conditions are:

1. Somatization Disorder
2. Undifferentiated Somatoform Disorder
3. Conversion Disorder
4. Pain Disorder
5. Hypochondriasis
6. Body Dysmorphic Disorder

XII. Factitious Disorders

(See pages 513-517 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 471-475]

Factitious Disorder and Malingering

- Malingering and Factitious Disorder both involve the intentional production (faking) or serious exaggeration of medical or psychological symptoms or conditions.
- In Malingering, the individual has an external incentive (money, getting out of work, etc.) that he/she hopes to achieve by his/her presentation.
- In Factitious Disorder, there is no apparent external motivation for the faking other than to receive medical attention.

XIII. Dissociative Disorders

(See pages 519-533 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 477-491]

Types of Dissociative Disorders

The DSM-IV presents four types of Dissociative Disorders which generally share a disruption in the usually integrated functions of consciousness, memory, identity, or perception. The four specific types are:

1. Dissociative Amnesia – inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
2. Dissociative Fugue – sudden unexpected travel away from home or one's customary place of work accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity.
3. Dissociative Identity Disorder – the presence of 2 or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
4. Depersonalization Disorder – a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing.

XIV. Sexual and Gender Identity Disorders

(See pages 535-582 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 493-538]

A. Major Divisions of Sexual Disorders

- The DSM-IV makes a primary distinction between sexual dysfunctions and paraphillias (sexual deviations).
- Sexual Dysfunctions involve a primary impairment in the sexual response cycle, such as in Premature Ejaculation or Female Orgasmic Disorder.
- The paraphillias involve a functional physiological sexual response which has been associated with an unnatural stimulus, such as seen in Voyerism, Rape, Pedophilia, and Frotteurism.
- The DSM-IV describes a large number of sexual disorders, particularly in the dysfunctions category, and should be consulted for details on these conditions.

B. Gender Identity Disorder

- The DSM-IV states that the major criteria for the diagnosis of Gender Identity Disorder is a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- It is stated to have no specific relationship to sexual orientation or to transsexualism.

XV. Eating Disorders

(See pages 583-595 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 539-550]

Anorexia versus Bulimia

Distinguishing between Anorexia and Bulimia is a relatively straightforward presentation in the DSM-IV.

The diagnostic criteria for **Anorexia** involve:

- a refusal to maintain minimal body weight for age and height
- an intense fear of weight gain or becoming fat (even though under weight)
- a disturbance in the way one's body shape or weight is experienced. In postmenarcheal females, amenorrhea is also seen.

The three most common medical complications of people who are suffering from anorexia nervosa are:

- loss of menses (amenorrhea)
- constipation
- hypotension

Although Anorexia and Bulimia share an intense fear of weight gain and a significant disturbance in the perception of one's shape or size, **Bulimia** is easily differentiated as it involves recurrent episodes of binge eating and inappropriate compensatory behavior in order to prevent weight gain (self-induced vomiting, laxative use, or over-exercise).

Binging and compensatory behaviors both occur on average at least two times a week for three months.

Bulimia and Anorexia can be co-morbid (co-occur).

XVI. Sleep Disorders

(See pages 597-661 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 551-607]

General Organization

The DSM-IV presents the disorders of sleep under two general categories.

1. The **Dysomnias** centrally involve a difficulty in initiating or maintaining sleep, being excessively sleepy, or finding sleep to be of poor quality (nonrestorative). Examples are Insomnia and Sleep Apnea.
2. The **Parasomnias** involve abnormal behavioral or physiological events occurring in association with sleep stages or the transitions between sleep stages. Examples would be Sleep Terror Disorder, Sleepwalking, and Nightmare Disorder.

XVII. Impulse-Control Disorders

(See pages 663-677 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 609-621]

Assorted Impulse-Control Disorders

The DSM-IV includes a number of “habit” disorders in specific categories (e.g. Obsessive-Compulsive Disorder, Substance Dependence, and the Paraphillias). However, additional conditions not already presented are described in this small chapter, including:

- Pathological Gambling
- Kleptomania
- Intermittent-Explosive Disorder
- Trichotillomania

XVIII. Adjustment Disorders

(See pages 679-683 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 623-627]

Description of Short-term or Reactive Conditions

- According to the DSM-IV, an adjustment disorder is a psychological response to an identified stressor (nontraumatic) that results in the development of clinically significant emotional or behavioral symptoms.
- Symptoms must onset within three months of the stressful event and resolve within six months, unless the stressor is ongoing in nature.

XIX. Personality Disorders

(See pages 685-729 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 629-673]

Brief Descriptions of Personality Disorder Profiles

- In the DSM-IV, Personality Disorders are conceptualized as long-standing, chronic problems which create social or occupational impairment.
- More generally, Personality Disorders are most often evident in relational settings, where the rigid and irritating nature of interacting with others creates problems for the individual.
- The Personality Disorders presented in DSM-IV are summarized in the following table.

Disorder Name	DSM-IV Description
Paranoid Personality Disorder	a pattern of distrust and suspiciousness such that other's motives are interpreted as malevolent
Schizoid Personality Disorder	disinterested in social relationships, socially apathetic
Schizotypal Personality Disorder	a pattern of acute discomfort in close relationships, cognitive/perceptual distortions, and behavioral eccentricities
Antisocial Personality Disorder	a pattern of disregard for and violation of the right's of others
Borderline Personality Disorder	exhibits abrupt shifts in mood, has a poorly developed self-image, and demonstrates intense and unstable relationships
Histrionic Personality Disorder	a pattern of excessive emotionality and attention seeking
Narcissistic Personality Disorder	an inflated or grandiose sense of self; expects others to see them as specially gifted
Avoidant Personality Disorder	so highly sensitive to criticism and rejection that they may refuse to enter into social relationships
Dependant Personality Disorder	a pattern of submissive and clinging behavior related to an excessive need to be taken care of
Obsessive-Compulsive Personality Disorder	characteristics of orderliness, perfectionism, and rigidity without true obsessions or compulsions

XX. Other Conditions Which May be a Focus of Treatment

(See pages 731-742 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 675-686]

V-codes

In the DSM-IV, clinically-relevant conditions which do not meet the criteria for a formal mental disorder may often be adequately described and communicated to others via a V-code diagnosis.

A V-code indicates that the condition which is a focus, or even the primary focus, of clinical intervention is not attributable to a mental disorder.

Prominent examples include:

- Partner-Relational Problem (used for marital conflict)
- Academic Problem
- Malingering
- Bereavement
- Occupational Problem

GLOSSARY OF TECHNICAL TERMS

(See pages 819-829 in the DSM-IV-TR, 2000) [In Maroon DSM-IV, see pages 763-771]

IPGA suggests you look up unfamiliar terms found in the various diagnoses. Knowing what one term means can make the difference between additional confusion and clarity of an answer.

Chapter 3

Research Methods & Statistical Studies

RESEARCH METHODS AND STATISTICAL STUDIES

NCE – Chapter 3

Chapter Outline

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 - 2. Dependent
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RESEARCH METHODS AND STATISTICAL STUDIES

NCE – Chapter 3

RESEARCH

The term “research” is used in a variety of ways in everyday life. However, in the social sciences, "research" is used to describe **the application of a specific set of techniques based on what is often called the “scientific method.”** The scientific method involves drawing inferences about some *portion of reality* **based on** empirical/experimental *observations* (research) in order to better understand the significance of those *observations*.

There are distinct steps that are taken in conducting social scientific research:

- A thorough review of what is already known about the phenomenon in question (a “literature review”)
- A clear statement of the problem and any relevant subproblems
- Next, the researcher makes predictions about what is expected to be observed (stated in the **hypotheses**), and describes how the research is going to be conducted, using proper social scientific procedures.
- Once the research is completed, the observations and their relationships to BOTH the problem AND the hypotheses are described.
- Then the researcher interprets the observations in light of the original “knowledge” presented in the literature review.

Proper scientific procedures in the gathering and interpretation of facts determine the final quality of the research.

I. Introduction

A. Step 1

The process of reporting research begins with a **purpose statement** that identifies the variables being studied and the population to which they pertain.

There are three common types of variables in social research:

1. **Independent** – Independent variables are those that are manipulated or selected by the researcher to cause, influence, or otherwise effect the outcome.
 - To identify the independent variable(s), ask, “What is the name of the theory or technique the researcher is using to cause change?”
2. **Dependent** – Dependent variables are those that are affected or changed as a result of the manipulation of the independent variable(s).
 - To determine the dependent variable, ask, “What is the researcher attempting to measure or test?”
3. **Control** – Control variables are possible confounding variables that the researcher attempts to hold constant so that their effects are canceled out or controlled for, such as demographic or background characteristics of the subjects of a study.
 - To determine the control variable(s), ask, “What is the demographic or background information identified in the purpose statement?”

Sample Purpose Statement:

The purpose of this study is to compare the relative effectiveness of behavior therapy vs. physical therapy in reducing self-reported chronic lower back pain (CLBP), among adult males aged 40 - 60.

B. Step 2

The second step is to state the **hypothesis**. Pure experimental research is based on a **null hypothesis** — a statement that there is **no** true relationship existing between the independent and dependent variables.

Sample Null Hypothesis #1:

There is no significant difference between behavior therapy and physical therapy in reducing self-reported chronic lower back pain (CLBP), among adult males ages 40-60.

or

There is no significant difference in the reduction of self-reported chronic lower back pain (CLBP), among adult males ages 40-60, whether behavior therapy or physical therapy is used.

Sample Null Hypothesis #2:

There is no significant difference found between subjects' scores on the communication scale with respect to their success in forming friendships as measured by a sociogram.

II. Methodology

A. Four Types of Sampling Techniques

1. **Simple Random Sample** – In a **Simple Random Sample** each item/subject in a sample is considered to have an equal, independent chance of being selected "into" the sample.
2. **Stratified Random Sample** – In a **Stratified Random Sample** representative items/subjects are divided into *parts* (grades, ages, income, test scores, etc.). In each part, each item/subject has an equal, independent chance of being selected "into" the sample.
3. **Cluster Sample** – In a **Cluster Sample** *parts* that go together are researched/studied together (neighborhood, class, etc.).
4. **Systematic Random Sample** – In a **Systematic Random Sample** a **systematic** rule of selection or **predictable** interval is employed (every 3rd person, odd numbered, etc.).

ILLUSTRATION:

1. Simple Random Sample

Let's say we decide to do a study with children in a particular school district (out of many school districts in the state). We go to that district's superintendent and ask, "How many children are in your school district?" He replies, "10,000." If we wanted to do the project with 1,000 of these children, we would select the 1,000 students in a way that gives each and every student an equal, independent chance of selection. The 1,000 students selected are a **Simple Random Sample**. All of the children in the total 10,000 are considered to have had an equal, independent chance of selection.

2. Stratified Random Sample

But we might want to break these children down in some manner. "Mr. Superintendent, is there any way we can break these 10,000 children down in some way - - put them in categories?" "Why yes. There is a simple way. It's called grading. We have them divided by grades: grades K through 12." That makes it easy for us. *If we selected our sample of students randomly from within these categories/parts/strata, we would have a **Stratified Random Sample**.* We took what is equal, divided it into parts/strata, and then selected students randomly from each part/strata.

3. Cluster Sample

But if we decided to do our test only with 5th graders, we might ask, "Mr. Superintendent, does this grouping mean you have one school for all the 1st graders and one school for all the 2nd graders, etc.?" "No. We have combined schools. We have two elementary schools so that means we have 5th graders in two locations. Some are on the north side of town and some are on the south side of town." *If we decide to meet with the 5th graders from both schools on a Saturday morning at a football field and select our sample from that group, we would have a **Cluster Sample**.* We are taking the parts that go together.

4. Systematic Random Sample

So, let's meet that Saturday morning with our Cluster Sample and count them off: 1, 2, 3, 4, 5; 1, 2, 3, 4, 5; 1, 2, 3, 4, 5 AND THEN have all of the 1's, 3's, and 5's go to the other end of the field. *The technique we have used gives us a **Systematic Random Sample or Predictable Interval Sample** to work with.*

B. Important distinctions between pairs of similar terms

- 1a. **Population** – contains all subjects having a common characteristic.
- 1b. **Sample** – is made up of any subset of a population; the subjects are available to the researcher.

- 2a. **Sampling Error** – occurs when subjects are not under the researcher's control or when a discrepancy arises due to random sampling.
- 2b. **Sampling Bias** – is considered to be the researcher's fault when it occurs because it involves a researcher's selecting a non-representative sample for his/her own convenience or due to his/her own prejudices.

- 3a. **Random Selection** – is the process of obtaining a sample from a defined population, with every subject in the population having an equal, independent chance of being selected.
- 3b. **Random Assignment** – occurs after selection when the researcher divides the subjects from the sample into treatment groups.

C. Procedures

Researchers try to design valid studies, but confounding variables can pose a threat to a study's validity.

1. Threats to **internal validity** concern flaws in the design of the study. The following are types of threats to the internal validity of a study:

- a. **History** – When studies occur over a period of time, additional events may occur in subjects' lives which can affect the findings.

Control: Since these are unexpected events, they can't be controlled for. The researcher can only note these events in the results. However, random selection makes it likely that subjects in all groups (experimental and control) are impacted by these similar events. Therefore, random selection (attempts to) eliminates "bias" in the experimental or control groups.

- b. **Maturation** – Subjects grow up physically, emotionally, socially, cognitively, etc. while the researcher is conducting the study.

Control: Use two groups, both a Control group and an Experimental group.

- c. **Testing** – Pre-test/post-test designs require special attention since subjects may be more test-wise for the post-test or may even remember some answers or questions from the pre-test.

Control: Lengthen the time between the pre-tests and post-tests. Or, give the test to both the experimental and control group, so that both are influenced in the same way by having experienced the questions before.

- d. **Statistical Regression** – The tendency of extreme scores (both high and low) to move closer to the middle upon re-testing must be recognized.

Control: Sample carefully; don't select a sample containing subjects with extreme scores.

- e. **Subject Attrition** – Many different factors can cause subjects to drop out during the study. Attrition, or mortality, is the term used to describe this "drop-out" factor.

Control: Statistical manipulation of data can correct this.

2. Threats to **external validity** concern the extent to which the researcher can generalize findings to a larger population. Common threats to the external validity of a study include the following:

- a. **Multiple-Treatment Interference** – occurs when a researcher administers more than one treatment consecutively to the same subjects.

Control: Assign each subject only one treatment.

- b. **Hawthorne (placebo) Effect** – occurs when the *subjects'* knowledge that they are participants in a study alters or otherwise influences their usual responses.

Control: Have some sort of irrelevant treatment for the control group.

- c. **Novelty Effect** – occurs when *subjects* may show great gains at first because a treatment is something new, *but then* the gains diminish as the “new” wears off over time.

Control: Extend the treatment over a longer period of time.

- d. **Experimenter or Rosenthal Effect** – occurs when the *researcher/experimenter's* behavior or appearance affects the subject's performance.

Control: Use more than one experimenter for interrater reliability.

- e. **Halo Effect** – occurs when the *researcher/ experimenter* allows his/her initial impressions of subjects to influence later ratings of subjects.

Control: The researcher recognizes and notes the bias.

III. Research Methods and Designs

A. **Experimental Research** – is rigorously controlled and must meet **two criteria**:

1. The researcher must be able to control or manipulate independent variables.
2. Subjects must be randomly assigned.

Be familiar with **the Solomon Four Group Design**

(Also known as: **The Solomon 4,
The Solomon, and
A Four Group Design.**)

It is considered the best/strongest experimental design.

It allows the researcher to estimate the effect of treatment *and* the effect of a test while controlling for the testing effect (if it exists).

Below is the usual shorthand notation of the Solomon four-group design:

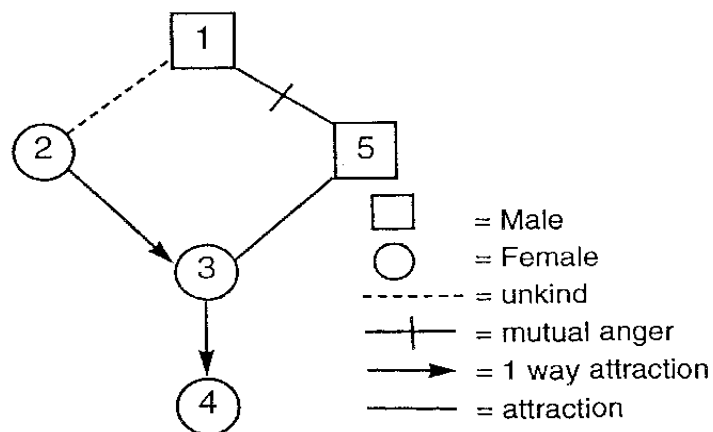
R	=	random assignment/selection
O1	=	pre-test, or first measurement
X	=	treatment/intervention
O2	=	post-test, or second measurement
-	=	nothing done (absence of treatment/intervention)

R group 1	O1	X	O2
R group 2	O1	-	O2
R group 3	-	X	O2
R group 4	-	-	O2

= an experimental group
= a control group
= an experimental group
= a control group

- One control group (R group 2) and one experimental group (R group 1) are BOTH pre-tested and post-tested.
- The other control group (R group 4) and the other experimental group (R group 3) are ONLY post-tested.
- The design is set up so that if there are effects caused by the pre-testing, those effects can be noted by comparing the results of the two experimental groups (R group 1 and R group 3) with each other and the results of the two control groups (R group 2 and R group 4) with each other.

- B. **Quasi-experimental Research** – is widely used in the counseling field. Only the **first** of the two criteria listed above for experimental research is met since subjects are usually not randomly assigned because the groups under study are already intact (classroom groups, etc.).
- C. **Correlational Research** – investigates relationships among variables with the results always expressed as a **correlation coefficient**. This type of research does not measure cause/effect relationships; it only measures correlation.
- D. **Descriptive Research** – is non-experimental and is used when the independent variables have already occurred, so the researcher cannot predict outcomes (state hypotheses). The researcher can only **describe** what already exists making this research *a study of the results*.
- E. **Action Research** – has as its purpose the development of new skills or approaches with direct applications for **counseling practitioners** or use within the **educational field**.
- F. **Outcome Research** – concerns itself with what happens to clients as a result of counseling.
- G. **Process Research** – examines the nature of the counseling interview and tries to determine what factors lead to successful outcomes.
- H. **AB Design** – is the simplest single-subject design. It includes one baseline phase (A) and one intervention phase (B).
- I. **ABAB Design** – is designed to better control for outside events. The 2nd “A” stands for a second baseline phase (which would occur after some period of time AFTER the withdrawal or removal of the intervention). The 2nd “B” stands for the RE-introducing of the intervention.
So, if you were to be asked to interpret what “ABA” represents, you would deduce that there has been an initial baseline established, an intervention has been introduced, and that the researcher has now withdrawn the intervention. After some period of time, another baseline will be established - thus the second “A.”
- J. **Sociogram** – is a specific technique for studying interaction patterns among **peers**.



IV. Types of Measurement Scales

Depending upon the variable, and the way in which it is measured, different kinds of data result, representing different levels of measurement. It is important to know which level of measurement is represented by your data since different statistics are appropriate for different levels of measurement. The acronym **N O I R** is used to remember these.

(KNOW IN THIS ORDER)

A. **Nominal or Categorical** – is the lowest and least precise level of measurement as it simply classifies or sorts persons and/or objects into categories — names of categories — hence the term "nominal."

Examples: yes/no
male/female
married/never married
married/divorced/widowed
Group 1/Group 2/Group 3

B. **Ordinal (Order)** – not only classifies subjects or their behaviors, but also **ranks** them in terms of the degree to which they possess a characteristic of interest. Intervals between ranks are **not equal**.

Examples: BA/MA/Ph.D.
1st Place/2nd Place/3rd Place
Freshman/Sophomore/Junior/Senior
Chapter 1/Chapter 2/Chapter 3/Chapter 4

C. **Interval (Equal)** – has all the characteristics of both a nominal and ordinal scale, but, in addition, it is based upon predetermined equal intervals.

Examples: 1, 2, 3 or 3, 2, 1
-1, -2, -3 or -3, -2, -1
20 degrees, 40 degrees, 60 degrees;
-20 degrees, -40 degrees, -60 degrees

Note: Most of the tests used in educational research, such as **achievement tests, aptitude tests, and intelligence tests**, represent interval scales. Interval scales **do not** have a **true zero point** (which means they CAN HAVE negative numbers).

D. **Ratio** – is the **highest**, most precise, level of measurement. A ratio scale has all of the advantages of the other types of scales and, in addition, it has a **true zero point** (NO negative numbers).

Examples: 5 lbs., 10 lbs., 15 lbs.
10 inches, 12 inches, 14 inches
25 cents, 50 cents, 75 cents, \$1.00

Note: Most *physical measures* represent ratio scales. Since most psychological measures do not represent ratio scales, ratio scales are **not** used very often in educational or counseling research.

DESCRIPTIVE STATISTICS

The first step in data analysis is to describe, or summarize, the data using descriptive statistics. Descriptive statistics permit the researcher to meaningfully describe many, many scores with a small number of indices. If such indices are calculated for a sample drawn from a population, the resulting values are referred to as statistics; if they are calculated for an entire population, they are referred to as parameters.

Every test yields a **raw score**, or the actual number of items a person answered **correctly**. But a raw score is often meaningless, so it must be converted into a **derived score**.

I. Types of Derived Scores

- A. Grade Equivalent (GE)** – denotes that average raw scores are assigned a grade-level value. We interpret a given score compared to other “x” graders: *This subject performed at an average/below average/above average level.*

Example: So, if a third (3rd) grader, Mary, scores a 4.5 on a reading test, the appropriate way to interpret/report the score is to say, “Mary scored above average in reading.”

Remember that when tests are standardized, subjects (Ss) at different grade levels do not receive the same test, so we **can’t compare across grade levels**.

Referring to the previous example, the only way you would know if Mary was reading at a 4.5 grade level (half-way through the fourth grade) is to give her the fourth grade reading test.

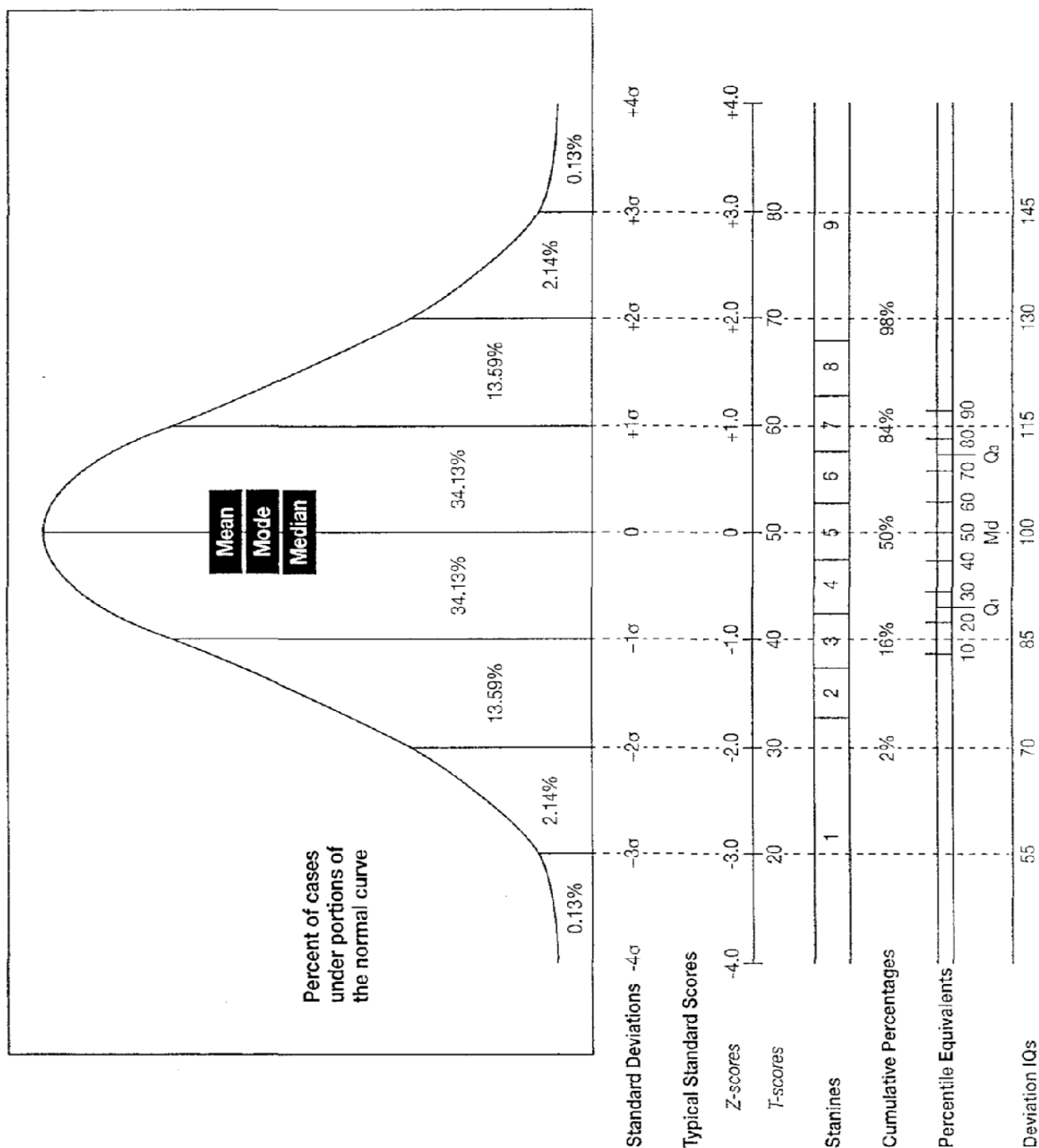
- B. Percentile Rank (PR or Pr)** – indicates the percentage of scores that fall **at or below** a given score.

Example: So, if John scored a 59 on a reading test and that score landed him at the PR of 45 (based on a graphing of the scores), the meaning is that 45% of the students who took the test earned scores of 59 or less.

- C. Standard Scores** – are derived from the normal curve.

1. **z-score** – is the most basic standard score and allows scores from different tests to be compared. The z-score has a mean of zero and a standard deviation (SD) of one.
(See the Normal Distribution/Bell Curve on the following page.)
2. **T-score** – is widely used and has a mean of 50 and a standard deviation (SD) of 10.
(See the Normal Distribution/Bell Curve on the following page.)
3. **Stanines** – (contraction of the two words "standard nine")
divide the normal curve into nine parts,
NOT NINE EQUAL PARTS.
(See the Normal Distribution/Bell Curve on the following page.)

II. Bell Curve



III. Tables and Graphs

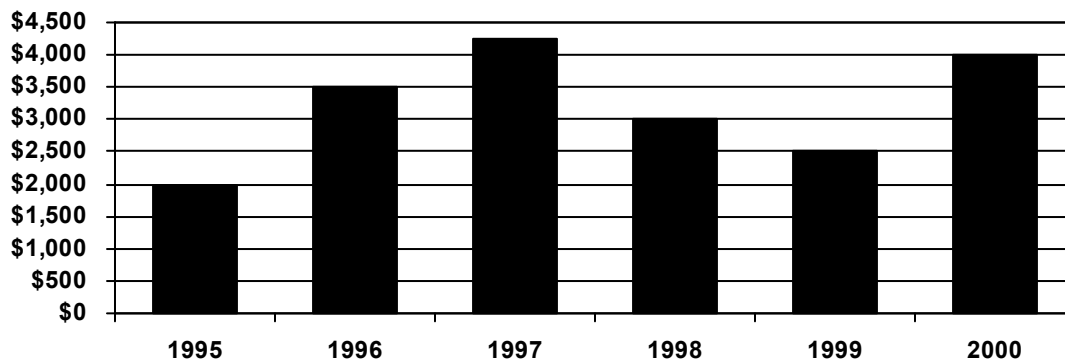
A. Tables

Three types of statistics are usually found in tables:

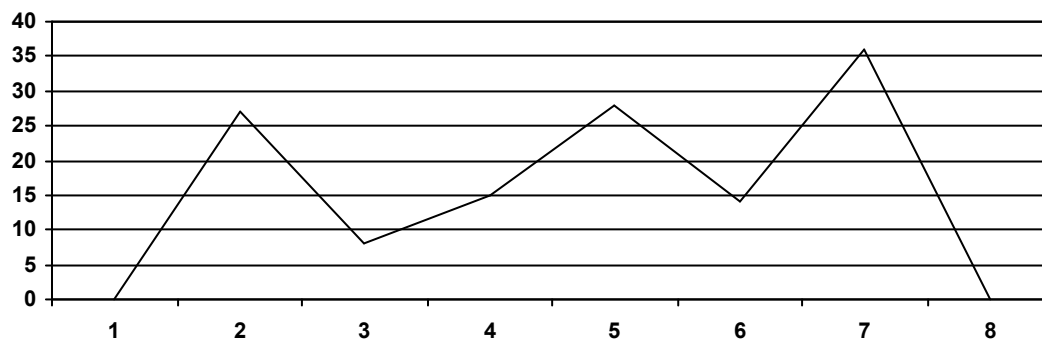
1. **Frequency (f)** – indicates the number of subjects (Ss) in a particular category; f = headcount.
2. **Proportion (p)** – indicates the ratio of a subgroup to the total group. Proportion is always expressed as a decimal from 0.0 to 1.0.
3. **Percentage (%)** – indicates the proportion of a subgroup to the total group and is always expressed as a percent from 0% to 100%.

B. Graphs

Graphs often take the form of bar graphs (also known as **histograms**) *or* frequency polygons. The most common method of graphing research data is the **frequency polygon/polygram**.



Bar Graph or Histogram



A Frequency Polygon/Polygram

IV. Measures of Central Tendency

Measures of central tendency give the researcher a convenient way of describing a set of data with a single number. The number that results from computation of a measure of central tendency represents the average or typical score attained by a group of subjects. Since most measurement in educational research represents an **interval scale**, the **mean** is the most frequently used measure of central tendency.

A. Mean (M; $\bar{x}$)

Mean is the arithmetic average of the scores and is the most frequently used measure of central tendency because it is more stable and precise. The mean is used with **interval** and **ratio** scales and is determined by calculation: Add or sum up the scores and divide that number (the sum) by the number of scores.

EXAMPLE: What is the mean for the following array of numbers:

7, 20, 5, 14, 30?

ANSWER: $7 + 20 + 5 + 14 + 30 = 76$

76 divided by 5 (the quantity of #s in array) = 15.2

B. Mode

Mode is the score attained by **more** subjects than any other score. The mode is not established through calculation; instead, it is determined by looking at a set of scores or at a graph of scores and seeing which score occurs **most frequently**. A set of scores may have two (or more) modes, in which case it is referred to as **bimodal** or **multi-modal**. Although the calculation of the mode can be done with any level of data, *it is the only appropriate measure of central tendency that is used with nominal data.*

MODE EXAMPLE #1: What is the mode of the following set of numbers: 17, 20, 23, 17, 6, 3, 1, 8, 14?

MODE ANSWER #1: Ask yourself, "Which number(s) occur MORE THAN the others or MOST?"

17 is the mode since it occurs most or more times.

MODE EXAMPLE #2: What is the mode of the following set of numbers: 14, 20, 23, 17, 6, 3, 1, 8, 17, 20, 12, 11, 17, 20?

MODE ANSWER #2: Ask yourself, "Which number(s) occur MORE THAN the others or MOST?"

This is a **bimodal** distribution. Both 17 and 20 occur three times and more than any other numbers in the array.

C. Median (MD or Md)

Median is that point in a distribution above which and below which are 50% of the scores; in other words, the median is the **midpoint (middle)**. It is not frequently used, but it is the best to use when a distribution has one or more **extremely high** or **extremely low** scores. *The median is the most appropriate measure of central tendency for ordinal level data.* The median is determined by:

- Step 1. Order the numbers, either highest-to-lowest or lowest-to-highest.
- Step 2. Divide the quantity of numbers (not their sum total) by two (2).
- Step 3. Using the number found in Step 2, count both up (lowest to highest) and down (highest to lowest) to find the middle number/mid-point.

MEDIAN EXAMPLE #1: What is the MD of the following array of numbers:
11, 41, 23, 2, 30, 7, 18, 4, 12?

MEDIAN ANSWER #1:

Step 1: Order the numbers: 2, 4, 7, 11, 12, 18, 23, 30, 41

Step 2: Divide the quantity of numbers (not their sum total) by two (2):
There are nine (9) numbers in the question.
 $9 \text{ divided by } 2 = 4.5$

Step 3: Now, go back to the ORDERED set of numbers and begin at one end and count 1, 2, 3, 4. The next number represents the .5 (of the 4.5) AND the answer to the question.
To check yourself, go to the opposite end of the set of ORDERED numbers and count 1, 2, 3, 4. The next number represents the .5 (of the 4.5) AND is your answer.

THE ANSWER IS THE NUMBER 12. It is the middle point of your distribution or array of numbers.

IMPORTANT NOTE: If you do NOT put your numbers in order (Step 1), there will be an answer on the exam to match your mistake in skipping this step. **For example**, in the original set of numbers (11, 41, 23, 2, **30**, 7, 18, 4, 12), the number 30 is in the .5 position of 4.5.

IF by chance you get an array of numbers that has an even number of numbers (say it has 10 numbers instead of 9, as in the example above), this is what you do:

- Step 1: Order the numbers, either highest-to-lowest or lowest-to-highest.
- Step 2: Divide the quantity of numbers (not their sum total) by two (2).
- Step 3: Using the number found in Step 2, count both up (lowest to highest) and down (highest to lowest) to find the middle number/mid-point.
- Step 4: Since you will have two different numbers, add those two numbers together and divide by two to get your answer.

MEDIAN EXAMPLE #2: What is the MD of the following array of numbers:
11, 41, 23, 10, 2, 30, 7, 18, 4, 12?

MEDIAN ANSWER #2:

- Step 1: Order the numbers:
2, 4, 7, 10, 11, 12, 18, 23, 30, 41
- Step 2: Divide the quantity of numbers (not their sum total) by two (2):
There are ten (10) numbers in the question. $10 \div 2 = 5$
- Step 3a: Now, go back to the ORDERED set of numbers and begin at one end and count 1, 2, 3, 4, 5. That 5th number is one part of your answer (THE NUMBER 11 in the above set of numbers if you count from THE LEFT).
- Step 3b: NOW, go to the **opposite end** of the set of ORDERED numbers and count 1, 2, 3, 4, 5. That 5th number is one part of your answer (THE NUMBER 12 in the above set of numbers if you count from THE RIGHT).
- Step 4: ADD 11 plus 12 = 23.
{ 11 (the 5th number from the left end) PLUS 12 (the 5th number from the right end) = 23.}
 $23 \div 2 = 11.5$ WHICH IS YOUR ANSWER. 11.5 is the middle point of your distribution or array of numbers.

V. Measures of Variability

Two sets of data that are very different can have identical means or medians. Thus, there is a need for a measure that indicates how spread out the scores are, how much variability there is.

A. Range (R)

Range is a crude measure of variability. It is simply the difference between the highest and lowest score in a distribution and is determined by subtraction.

EXAMPLE: What is the range of the following set of numbers:
11, 1, 7, 42, 83, 5?

ANSWER: Subtract the lowest from the highest: 83 minus 1 = 82.
The range is 82.

B. Standard Deviation (SD / σ)

Standard Deviation is the **most often** used measure of variability as it describes how scores vary around the mean. The **larger** the SD, the **greater** the variability among scores.

ON THE EXAM, if you are asked to calculate the standard deviation for an array of numbers, remember you do NOT have to know an elaborate formula. For the exam, plan to get a **“CLOSE-ENOUGH or the CLOSEST”** standard deviation by following these steps:

STEP ONE: Subtract the lowest from the highest. (This step determines the Range.)

STEP TWO: Divide the Range by the number six (6).

EXAMPLE: Calculate the SD for: 11, 1, 117, 7, 42, 83, 5, 121, 14, 23, 111

ANSWER: Step one: Subtract the lowest from the highest: 121 minus 1 = 120.

Step two: 120 divided by 6 = 20 which is a **“CLOSE ENOUGH”** standard deviation for the exam, i.e. you then select the answer that is **CLOSEST** to 20 to plot on your bell curve. For instance, you would select 20 as your Standard Deviation from the following choices:
a. 30.0 b. 15 c. 20 d. 40

NOTE: Since you are not allowed to take a calculator in with you, it is highly likely that any calculations will be “arranged” around numbers easily done in long-hand or in your head.

C. Variance (as it relates to Standard Deviation)

Variance is one way to measure or describe the variation of/between data (*just like the term standard deviation describes how data vary around the mean/median/mode*).

To find the variance, square the standard deviation:

If you have a standard deviation of 6, the variance is 36 (6 times 6).

If you have a standard deviation of 9, the variance is 81 (9 times 9).

If you have a standard deviation of 16, the variance is 256 (16 times 16).

If you are given the variance and need to calculate the standard deviation, you need to find/calculate the positive square root of the variance.

If you have a variance of 100, the standard deviation is 10 (10 times 10 = 100).

If you have a variance of 16, the standard deviation is 4 (4 times 4 = 16).

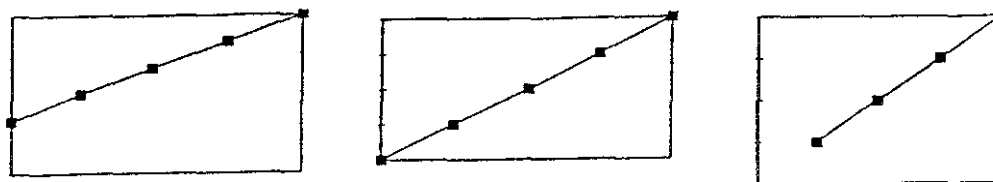
If you have a variance of 64, the standard deviation is 8 (8 times 8 = 64).

VI. Measures of Relationship

The degree of relationship between **two** variables is expressed as a **correlation coefficient**. Correlations tell the direction and the strength of the relationship. The closer to 1 (either a +1 or a -1), the stronger the correlation.

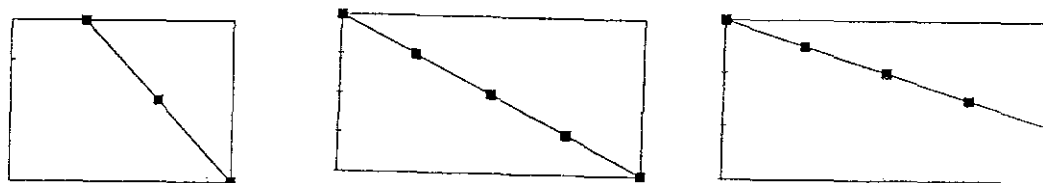
- A. If two variables are **positively** and directly related (as X increases, Y also increases or as X decreases, Y also decreases), the correlation coefficient will be close to +1.0, a perfect positive relationship.

Example: The relationship between exercise and muscle tone.



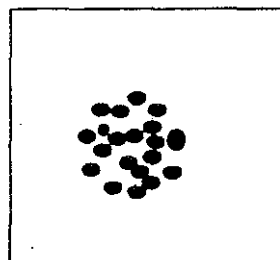
- B. If two variables are **negatively** and directly related (as X increases, Y decreases, or as X decreases, Y increases), the correlation coefficient will be close to -1.0, a perfect negative or inverse relationship.

Example: The relationship between amount of exercise and percentage of body fat.



- C. If two variables are **not related**, the correlation coefficient will be close to 0.

Example: The relationship between IQ and shoe size.



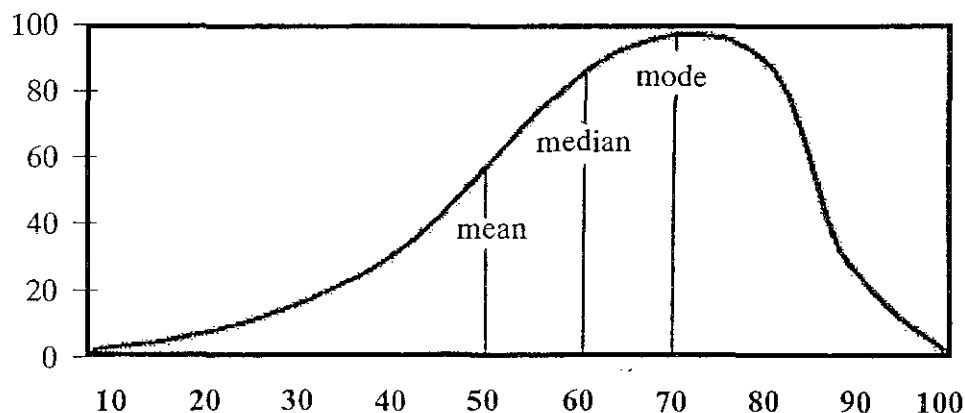
0.00 = No correlation

- These are the two most widely used correlations:
 - a. The **Pearson product-moment correlation (Pearson r)**, which is used for **interval** or **ratio** measures.
 - b. The **Spearman rho**, which is used for **ordinal** data.

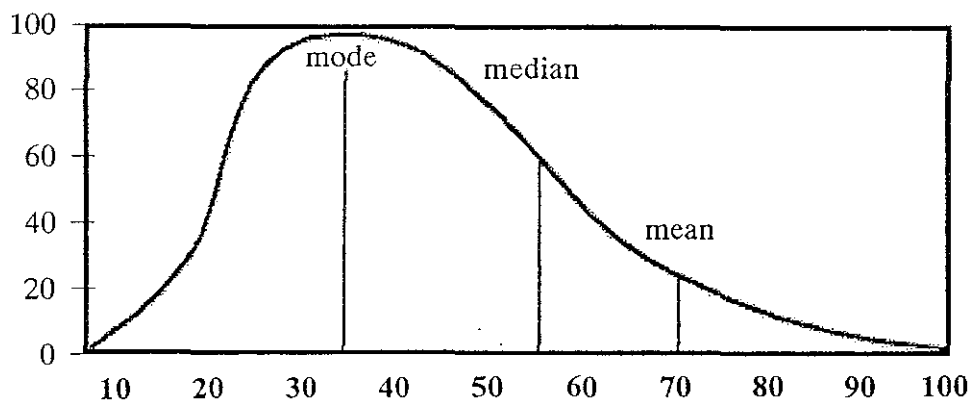
VII. Skewed Distributions

When a distribution is not normal, it is said to be **skewed**. A distribution which is skewed is not symmetrical, and the values of the mean, the median, and the mode are different.

- A. Negative skew:** The mean is pulled in the direction of low scores (the tail to the left). If a distribution is negatively skewed, the mean would be **smaller** than the median.



- B. Positive skew:** The mean is pulled in the direction of the high scores (the tail to the right). When a distribution is positively skewed, the mean is **larger** than the median.



REMEMBER: The mean goes in the direction of the tail.

OR

The tail tells the tale.

C. Degree or Amount of Skew

To determine the degree to which a distribution is skewed, remember this formula:

$$\text{Mean minus Median} = \text{Skew}$$

EXAMPLE #1: If the Mean of a distribution is 200 and the Median score is 190, the degree of skewedness is 10 (and in this case the distribution is positively skewed).

EXAMPLE #2: If the Mean of a distribution is 60 and the Median score is 72, the degree of skewedness is -12 (and is a negatively skewed distribution).

SAMPLE PROBLEM:

Which of the following distributions is more greatly skewed?

- a. Mean = 70; Median = 60
- b. Mean = 75; Median = 62
- c. Mean = -65; Median = -87
- d. Mean = -82; Median = -70

The correct answer is: c.

- a. $70 - 60 = \text{range of } 10$
- b. $75 - 62 = \text{range of } 13$
- c. $-65 - [-87] = \text{range of } 22 \dots -22$
- d. $-82 - [-70] = \text{range of } 12 \dots -12$

IT DOES NOT MATTER WHETHER THE NUMBER IS POSITIVE (indicating a positive skew) OR NEGATIVE (indicating a negative skew). Select the largest number because it indicates the greatest amount of skew.

EXAMPLE: What type of distribution do the following numbers represent:

11, 41, 23, 2, 30, 7, 18, 4, 12?

- a. A normal distribution
- b. A positively skewed distribution
- c. A negatively skewed distribution
- d. An inverted distribution

To answer such a question complete the following 3 processes:

Process # 1: Calculate the mean or average

Process # 2: Calculate the median or mid-point

Process # 3: Determine the answer:

- A. IF BOTH NUMBERS (the mean and the median) ARE THE SAME – EXACTLY THE SAME – you have a normal distribution (the Bell curve).
- B. If the mean is smaller than the median, you have a negatively skewed distribution.
- C. If the mean is larger/bigger than the median, you have a positively skewed distribution.

Process # 1: Calculate the mean or average:

$$11 + 41 + 23 + 2 + 30 + 7 + 18 + 4 + 12 = 148$$

$$148 \text{ divided by } 9 = 16.44$$

The mean is 16.44.

Process # 2: Calculate the median or mid-point:

(There are 9 numbers in the array, therefore, there are 3 Steps in the solution)

Step 1: Order the numbers: 2, 4, 7, 11, 12, 18, 23, 30, 41.

Step 2: Divide the quantity of numbers (not their sum) by two (2):
There are nine (9) numbers.
 $9 \text{ divided by } 2 = 4.5$

Step 3: Now, go back to the ORDERED set of numbers and begin at one end and count 1, 2, 3, 4. The next number is the .5 (of the 4.5) AND the answer to the question (the number 12).
To check yourself, go to the opposite end of the set of ORDERED numbers and count 1, 2, 3, 4. The next number is the .5 (of the 4.5) AND is your answer (the number 12).

THE MEDIAN or midpoint is 12.

Process # 3: Determine the answer:

The mean (16.44) is bigger than/larger than the median (12).
THEREFORE, these numbers represent a positive skew or a positively skewed distribution.

- EXAMPLE:** What type of distribution do the following numbers represent:
11, 41, 23, 10, 2, 30, 7, 18, 4, 12?
- a. A normal distribution
 - b. A positively skewed distribution
 - c. A negatively skewed distribution
 - d. An inverted distribution

To answer such a question complete the following 3 processes:

Process # 1: Calculate the mean or average

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Process # 3: Determine the answer:

- A. IF BOTH NUMBERS (the mean and the median) ARE THE SAME - EXACTLY THE SAME - you have a normal distribution (the Bell curve).
- B. If the mean is smaller than the median, you have a negatively skewed distribution.
- C. If the mean is larger/bigger than the median, you have a positively skewed distribution.

Process # 1: Calculate the mean or average:

$$11 + 41 + 23 + 10 + 2 + 30 + 7 + 18 + 4 + 12 = 158$$

$$158 \text{ divided by } 10 = 15.8$$

The mean is 15.8.

Process # 2: Calculate the median or mid-point:

(There are 10 numbers in the array, therefore, there are 4 Steps in the solution)

Step 1: Order the numbers: 2, 4, 7, 10, 11, 12, 18, 23, 30, 41.

Step 2: Divide the quantity of numbers (not their sum) by two (2):
There are ten (10) numbers.
 $10 \text{ divided by } 2 = 5$

Step 3: Now, go back to the ORDERED set of numbers and begin at the left hand side and count 1, 2, 3, 4, 5. The 5th number is 11.

Now begin at the right hand side and count 1, 2, 3, 4, 5. The 5th number is 12.

$$\text{Step 4: } 11 + 12 = 23. \quad 23 \text{ divided by } 2 = 11.5$$

THE MEDIAN or midpoint is 11.5.

Process # 3: Determine the answer:

The mean (15.8) is bigger than/larger than the median (11.5). THEREFORE, these numbers represent a positive skew or a positively skewed distribution.

INFERENTIAL STATISTICS

Inferential statistics are used to make inferences about the larger population and are concerned with generalizing from sample to population.

I. Level of Significance

Level of Significance has to do with the researcher's decision of how and/or when to accept or reject the null hypothesis and state that there is or isn't a significant difference. The Level of Significance is most frequently set at **.01 or .05** in our field. A .05 level of significance corresponds to a .95 level of confidence. So, both a .05 level of significance AND a .95 level of confidence means that the results of a study would be due to chance only 5 or fewer times out of 100.

II. Types of Error

Types of Error are noted by **Type I/Alpha** or **Type II/Beta**. The true status of the null hypothesis is determined.

A. Type I/Alpha Error: A null hypothesis is rejected when no differences exist. Remember, a null hypothesis is stated, "There is no significant difference....." In a Type I or Alpha Error, the researcher says there **is** a significant difference (thereby rejecting the null hypothesis) when there really **isn't** a significant difference. In other words, the researcher rejects the null hypothesis as originally stated when he/she should have accepted it.

B. Type II/Beta Error: A null hypothesis is accepted or retained when differences do exist. Remember, a null hypothesis is stated, "There is no significant difference...." In a Type II or Beta Error, the researcher says there **is no** (significant) difference (thereby accepting the null hypothesis) when there really **is** a significant difference. In other words, the researcher accepts the null hypothesis as originally stated when he/she should have rejected it.

Example: There is no significant difference found between subjects who score on the communication scale with respect to their success in forming friendships as measured by a sociogram.

An **Alpha/Type I Error** would say, "Our research shows that there IS significant difference between subjects." In reality, their research was incorrect and they should have accepted their original null hypothesis as stated.

A **Beta/Type II Error** would say, "We found our null hypothesis to be true as stated. There is no significant difference between subjects." However, their research was incorrect and they should have rejected their null hypothesis saying, "There is significant difference...."

III. Most Commonly Used Types of Inferential Statistics

- A. **Chi²** – is used with **nominal** data and compares observed frequencies with expected frequencies. It may be used when a study has only **one** group of subjects.
- B. **T-test** – is used to determine whether there is a statistical significance between the **means** of **two** groups. It is used with **interval and ratio** scale data and when the researcher has a treatment group(s) and a control group to see if the treatment makes a difference.
- C. **ANOVA** (Analysis of Variance) - is like **multiple T-tests** and is used with **three or more** groups.

MANOVA (Multiple or Multivariate Analysis of Variance)

Shows the correlation between each independent variable and the dependent variable (because multiple independent variables are used).

ANCOVA (Analysis of Covariance)

Shows how a covariate interacts (co-varies) with the dependent variable. A covariate is a variable correlated with the dependent variable.

IV. Statistical Abbreviations

SD	standard deviation	M	mean
$\bar{\sigma}$	standard deviation	$\bar{x}$	mean
GE	grade equivalent	n	number
MD/Md	median	r	relationship
f	frequency	<i>p</i>	probability
Ss	subjects	%	percentage
Q ₁	quartile one (1) = 25%	S	stimulus
Q ₃	quartile three (3) = 75%	R	range
SEM	Standard Error of Measurement (see 2 nd page of Appraisal or Assessment Techniques chapter)	p	proportion

STATS PRACTICE QUESTIONS

1. If a test has a mean of 100 and a standard deviation of 15, we know that:
 - a. 50% of the respondents scored between 100 and 115.
 - b. 68% of the respondents scored above 85.
 - c. 50% of the respondents scored between 85 and 115.
 - d. 96% of the respondents scored between 70 and 130.

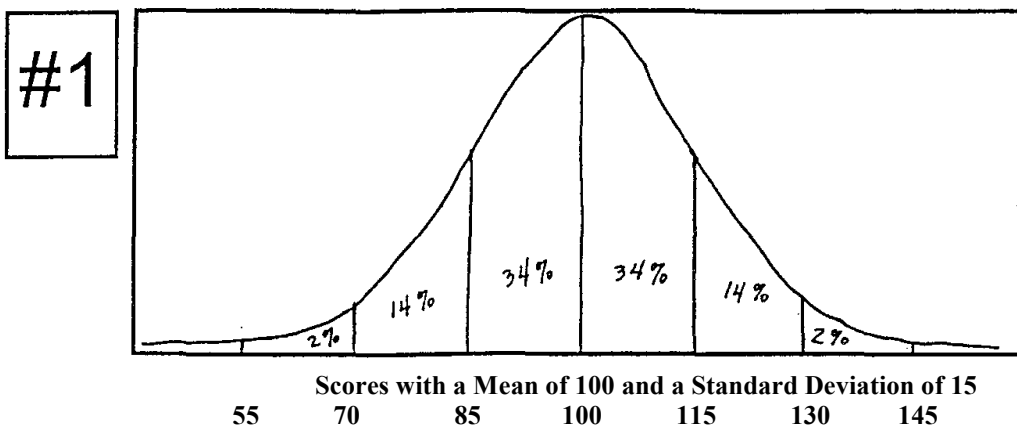
2. For a test, the mean was 60, the SD was 12, the MD was 60, $Q1 = 52$, $Q3 = 67$, and your $n = 900$.
How many examinees scored above 67?
 - a. 225
 - b. 275
 - c. 325
 - d. 175

3. Given the same information above, if Tom scored a 72, at what percentile rank does his score fall?
 - a. 68%
 - b. 74%
 - c. 84%
 - d. 92%

4. Given the same information above, what range of scores below represents $f=600$?
 - a. 48-72
 - b. 36-60
 - c. 60-84
 - d. 48-84

5. Bill took a math test and scored 560. The test has a mean of 500 and a SD of 100 in a normal distribution. What is his *z-score*?
 - a. +56.0
 - b. +.60
 - c. -560
 - d. Not enough information

6. Mary took a reading test and scored 225. The test has a mean of 450 and a SD of 150 in a normal distribution. What is her *z-score*?
 - a. +70
 - b. -1.5
 - c. -.5
 - d. Not enough information



Cumulative Percentages:

2%	16%	50%	84%	98%
	2%	16%	50%	84%
	+14%	+34%	+34%	+14%

A. INCORRECT

Locate the scores of 100 and 115. What percentage(s) (under the Bell Curve) represent this span of scores? The answer — 34%. So the 50% suggested in answer “a” is not correct.

OR PUT ANOTHER WAY — The distance between 100 and 115 is one (1) standard deviation. The percentage of scores under the bell curve (at the top of the page) between the mean of 100 and 115 is 34% NOT the 50% suggested in the answer.

B. INCORRECT

Locate the score 85. Now add together the percentages (under the bell curve) which represent the scores above 85:

$$\begin{aligned}
 85 - 100 &= 34\% \\
 100 - 115 &= 34\% \\
 115 - 130 &= 14\% \\
 130 - 145 &= 2\% \\
 34\% + 34\% + 14\% + 2\% &= 84\%
 \end{aligned}$$

Answer “b” suggests that 68% of the people scored above 85.

Our calculations show that **84%** scored above 85. So “b” is **not** the correct answer.

C. INCORRECT

Locate the scores of 85 and 115. What percentage(s) (under the Bell Curve) represent this span of scores? The answer — **68%**:

$$\begin{aligned}
 85 \text{ to } 100 &= 34\% \\
 100 \text{ to } 115 &= 34\%
 \end{aligned}$$

So the 50% suggested in answer “c” is not correct.

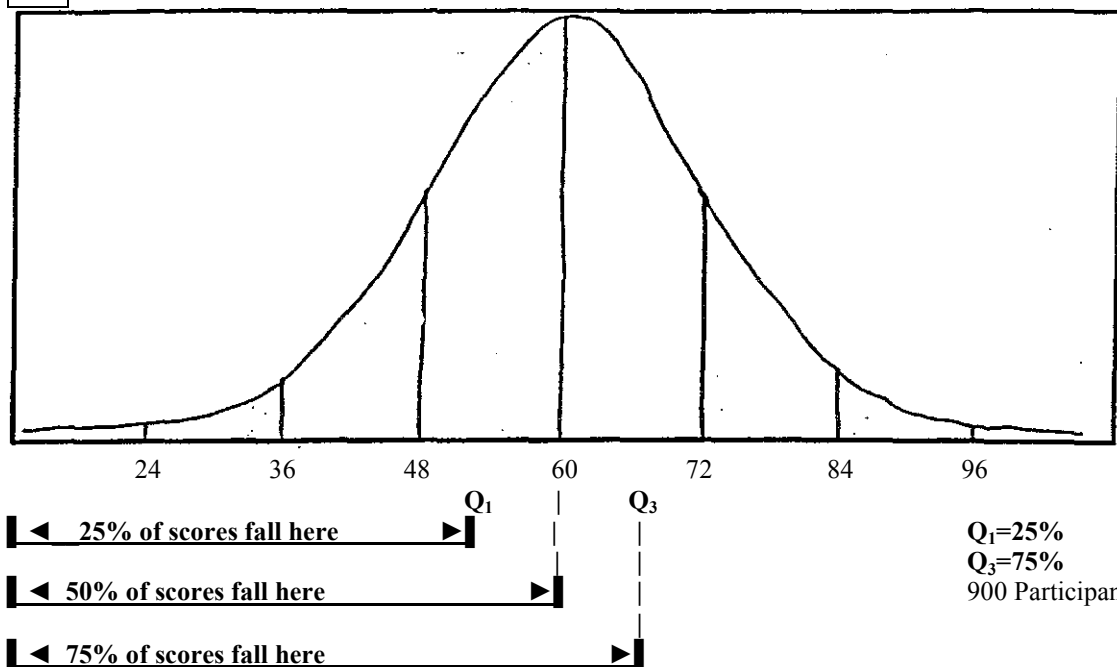
D. THIS IS THE CORRECT ANSWER

Locate the scores of 70 and 130. What percentage(s) (under the Bell Curve) represent this span of scores?

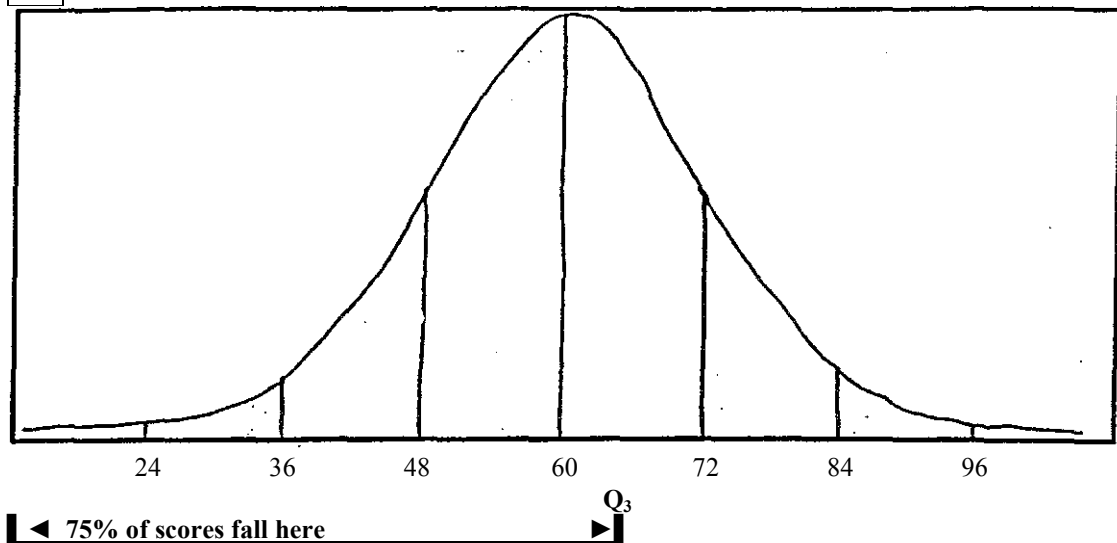
$$\begin{aligned}
 70 - 85 &= 14\% \\
 85 - 100 &= 34\% \\
 100 - 115 &= 34\% \\
 115 - 130 &= 14\% \\
 14\% + 34\% + 34\% + 14\% &= 96\%
 \end{aligned}$$

Answer “d” suggests that 96% of the respondents scored between 70 and 130. Our calculations confirm this.

#2 Part A of Visual Answer



#2 Part B of Visual Answer



75% scored 67% or less

So 25% scored above 67%

900

$\times .25$ (25 %)

225

225 Participants scored above 67%

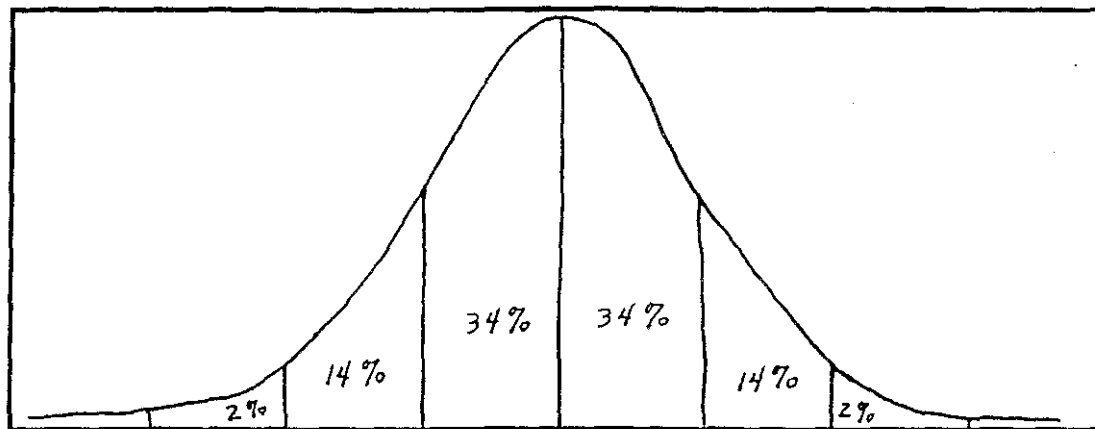
#2 Written description of the answer

The best way to answer this question is to know what the data in the question tells you. You would have to have elaborate graphing equipment to graph it exactly and precisely. You would spend too much time answering the question in such a manner.

Here's the important information:

- For this question, you need to know that Q_3 (found on the page showing the Bell Curve - just below the line labeled "Percentile Equivalents") is relevant.
- Q_3 stands for Quartile 3 or the 3rd Quartile ($3/4$) and represents 75%. What this lets you know is that 75% of the students scored a 67 or less. In other words 75% of the students scored between 0 and 67. Since 75% scored 67 or less, 25% scored ABOVE 67. 25% of 900 (the "n" or number of participants) 225.

The correct answer is "a" 225.

#3

Scores with a Mean of 60 and a Standard Deviation of 12

24 36 48 60 72 84 96

Cumulative Percentages:

2%	16%	50%	84%	98%
	2%	16%	50%	84%
	+14%	+34%	+34%	+14%

The correct answer is "c" - 84%.

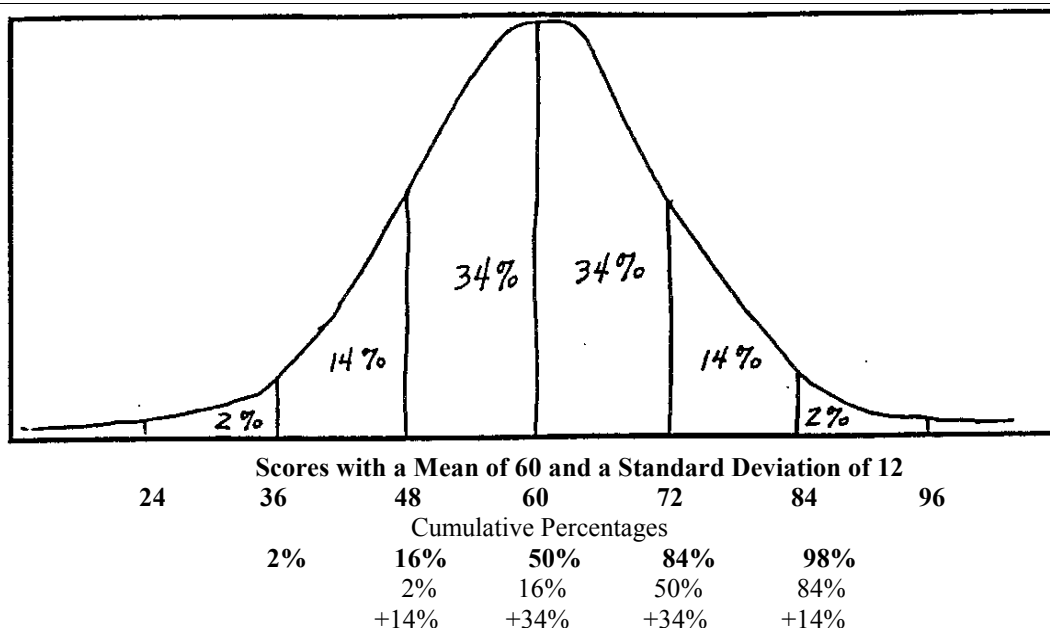
After you chart the information given to you in the question, you see that Tom's score of 72 falls at the 84th percentile based on cumulative percentages.

Answer "a" of 68% is NOT a given cumulative percentage (it is a combination of 34% + 34%).

Answer "b" of 74% is NOT a given cumulative percentage (it is erroneous).

Answer "d" of 92% is NOT a given cumulative percentage (it is erroneous).

#4



The answer is “a” - 48-72.

In answering this question, you have to use the additional information given to you in the original question.

“f” stands for frequency or the number of subject’s scores that fall at a specific score or the number of subject’s scores that fall between a range of scores.

The question is coming at you “backwards.”

Instead of giving you a range of scores and asking what frequency the scores fall at, the question:

1. gives you the frequency
2. asks you to calculate the percentage represented by the frequency (when compared to the total “n” of the study)

AND THEN

3. asks you to determine the range of scores represented by that percentage.

Here is what you do to answer it:

600 (“f”) divided by 900 (“n”) = $\frac{2}{3}$ or 66%.

The next step is to look for the percentage of scores under the Bell Curve that add up to CLOSE ENOUGH (since we are using cumulative Percentages) to 66%.

$34\% + 34\% = 68\%$ is the closest to 66% of any combination of consecutive percentages.

The final step — Look at the range of scores (which is what the question is asking for) that fall under these two areas of the Bell Curve ($34\% + 34\%$). The scores that fall between the $34\% + 34\%$ are “bounded” by 48 on the left hand side and 72 on the right hand side. Thus, the answer is “a” - 48 - 72.

Answer “b” of 36- 60 is NOT correct. Scores of 36 - 60 include the percentages of: $14\% + 34\% = 48\%$.

Answer “a” is represented by 68% which is closer to the 66% we are looking for.

Answer “c” of 60 - 84 is NOT correct. Scores of 60 - 84 include the percentages of $34\% + 14\% = 48\%$.

Answer “a” is represented by 68% which is closer to the 66% we are looking for.

Answer “d” of 48 - 84 is NOT correct. Scores of 48 - 84 include the percentages of: $34\% + 34\% + 14\% = 82\%$.

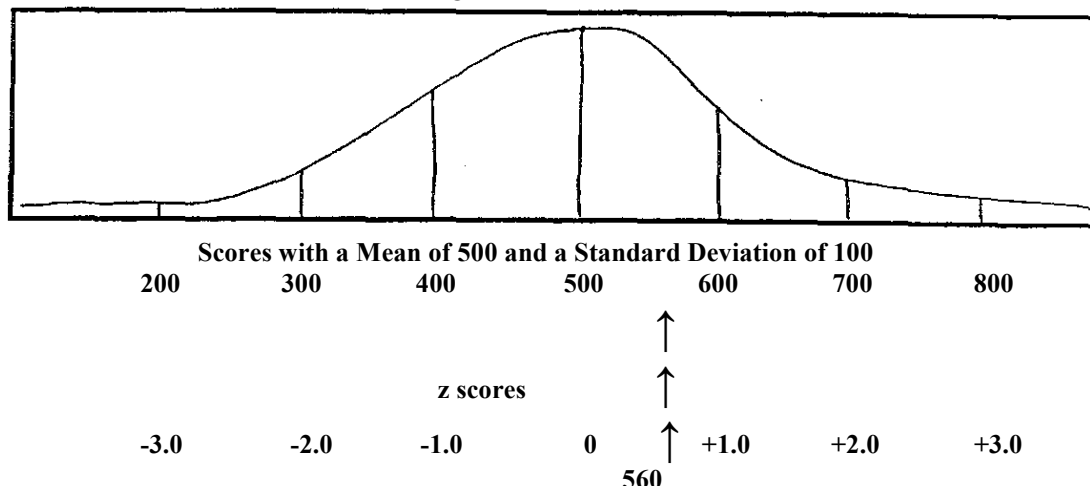
Answer “a” is represented by 68% which is closer to the 66% we are looking for.

#5

Bill took a test and scored 560. The test has a mean of 500 and a SD of 100 in a normal distribution.

What is his z-score?

- a. +56.0
- b. +.60
- c. -560
- d. Not enough information



SOLUTION A: In relation to the z-scores, 560 falls between zero (0) and plus one (+1). The closest answer of the four given is "b" (+.60).

SOLUTION B:

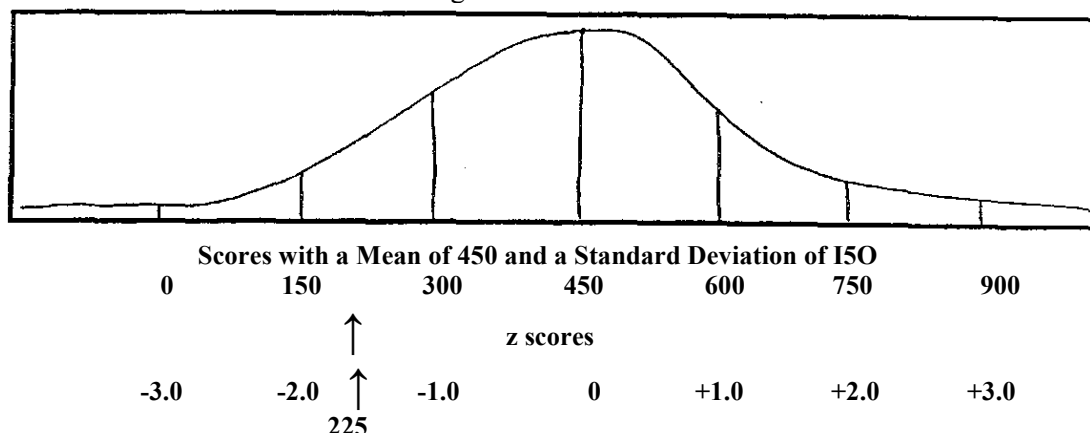
The actual calculation is: $\frac{\text{Raw Score} - \text{the Mean}}{\text{Standard Deviation}} = \frac{560 - 500}{100} = \frac{60}{100} = +.60$

#6

Mary took a reading test and score 225. The test has a mean of 450 and a SD of 150 in a normal distribution.

What is her z-score?

- a. +70
- b. -1.5
- c. -.5
- d. Not enough information



SOLUTION A: In relation to the z-scores, 225 falls between minus one (-1.0) and minus two (-2.0). The closest answer of the four given is "b" (-1.5).

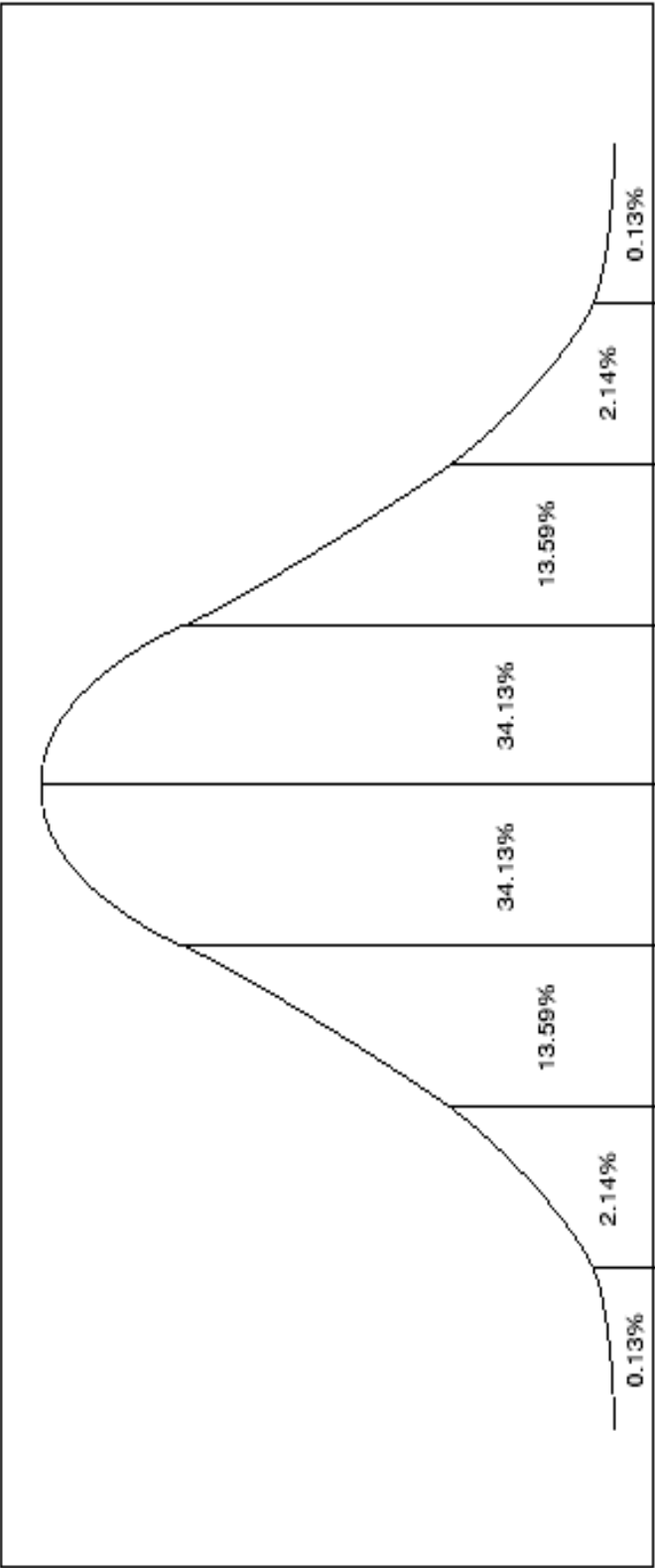
SOLUTION B:

The actual calculation is: $\frac{\text{Raw Score} - \text{the Mean}}{\text{Standard Deviation}} = \frac{225 - 450}{150} = \frac{-225}{150} = -1.5$

“any subset of a population”

Which of the following answers most closely correlates to the term that is studied in conjunction with the above referenced definition?

- a. Sample**
- b. Selection**
- c. Population**
- d. Status**

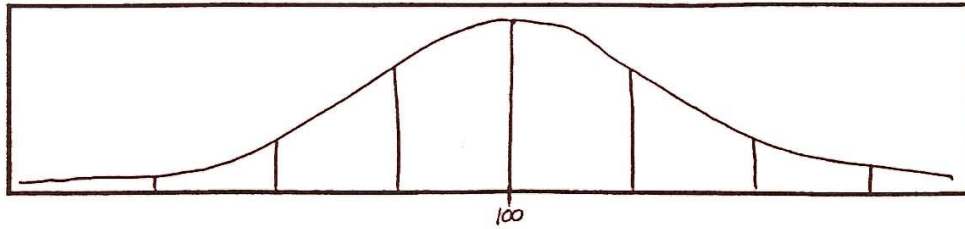


Standard Deviations	-4σ	-3σ	-2σ	-1σ	0	+1σ	+2σ	+3σ	+4σ			
Typical Standard Scores												
Z-scores	-4.0	-3.0	-2.0	-1.0	0	+1.0	+2.0	+3.0	+4.0			
T-scores		20	30	40	50	60	70	80				
Stanines		1		2	3	4	5	6	7	8	9	
Cumulative Percentages			2%	16%	50%	84%	98%					
Percentile Equivalents				10	20	30	40	50	60	70	80	90
				Q ₁				Md			Q ₃	
Deviation IQs		55	70	85	100	115	130	145				

z-scores

QUESTIONS

SIDE
ONE



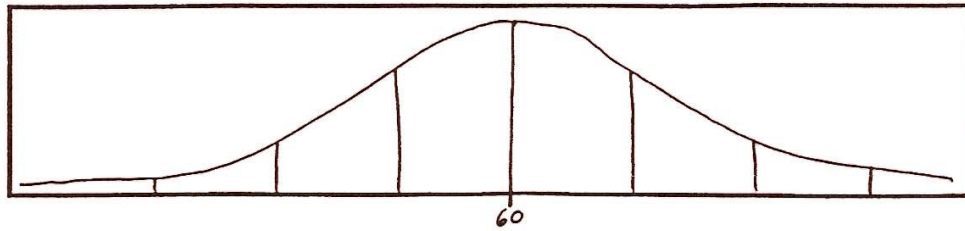
$$m = 100$$

$$\bar{\sigma} = 25$$

$$\text{Tom's Score} = 60$$



T-scores



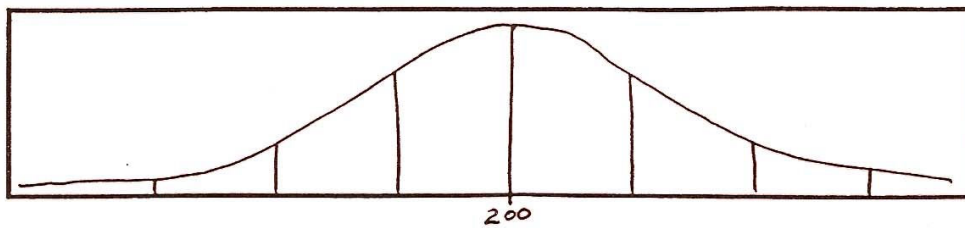
$$m = 60$$

$$\bar{\sigma} = 30$$

$$\text{Joe's Score} = 15$$



Stanines



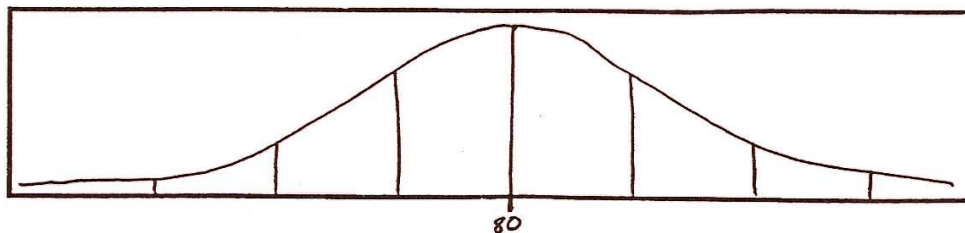
$$m = 200$$

$$\bar{\sigma} = 15$$

$$\text{Mary's Score} = 225$$



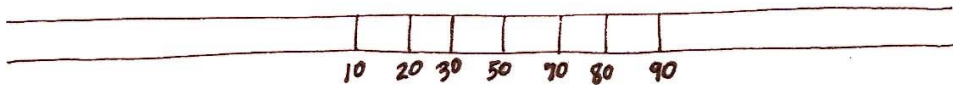
Percentile Equivalents



$$m = 80$$

$$\bar{\sigma} = 40$$

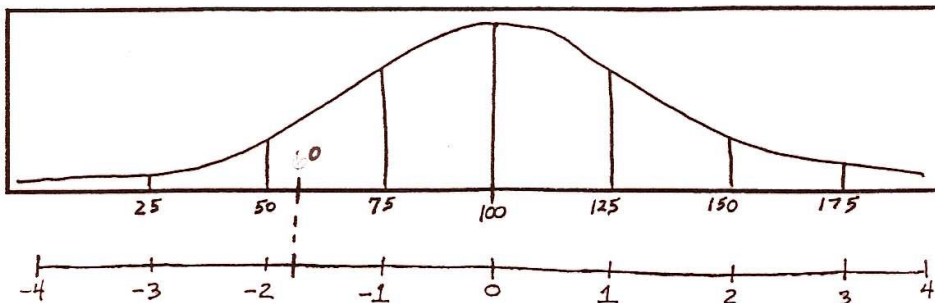
$$\text{Rhonda's score} = 50$$



z-scores

ANSWERS

SIDE TWO



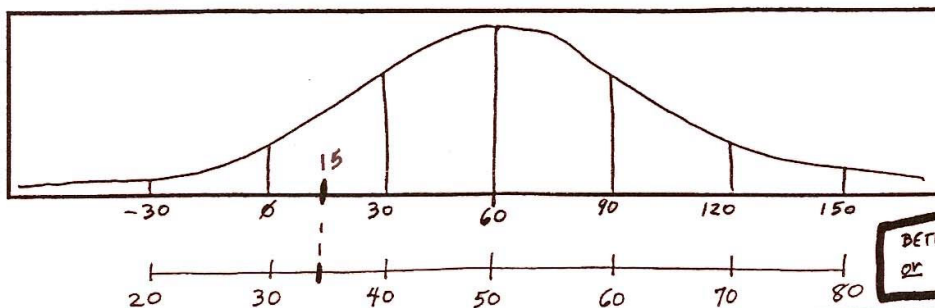
$$m = 100$$

$$\bar{\sigma} = 25$$

$$\text{Tom's Score} = 60$$

BETWEEN -1 AND -2

T-scores



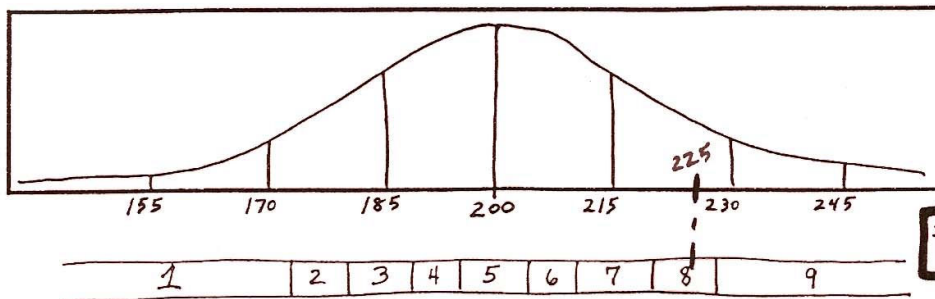
$$m = 60$$

$$\bar{\sigma} = 30$$

$$\text{Joe's Score} = 15$$

BETWEEN 30 AND 40
OR EXACTLY 35

Stanines



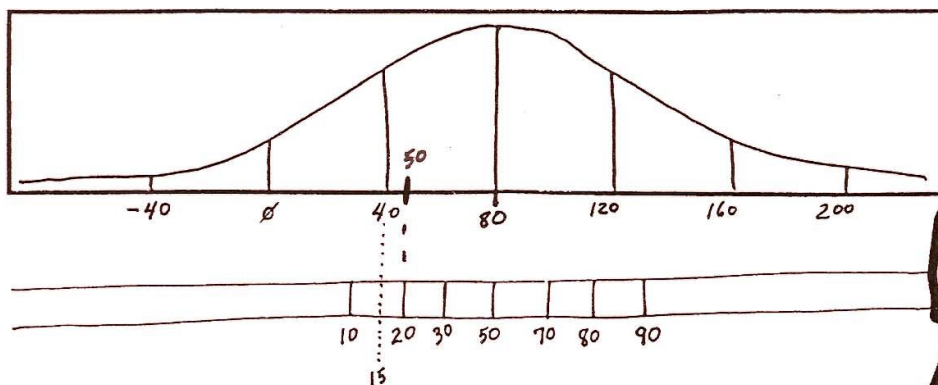
$$m = 200$$

$$\bar{\sigma} = 15$$

$$\text{Mary's Score} = 225$$

IN THE 8th
STANINE

Percentile Equivalents



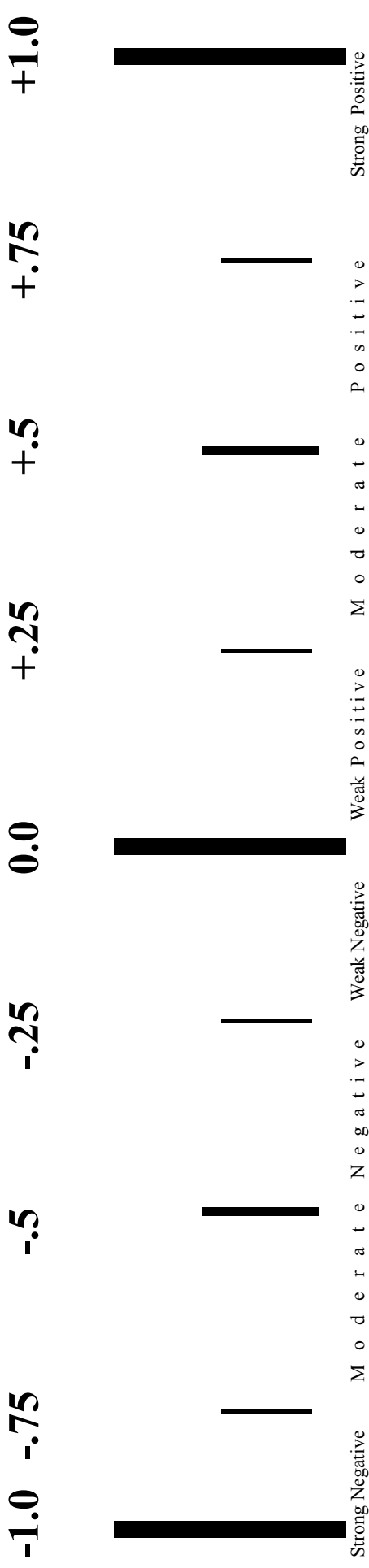
$$m = 80$$

$$\bar{\sigma} = 40$$

$$\text{Rhonda's score} = 50$$

APPROXIMATELY
THE 20th OR
BETWEEN 15 AND 30

ANSWERS



0.0 — .24 = Weak

+ .23 = Weak Positive

.25 — .74 = Moderate

-.68 = Moderate Negative

.75 — 1.0 = Strong

+ .87 = Strong Positive

Correlation Coefficients

LEVEL OF
SIGNIFICANCE
(Alpha Level)

LEVEL OF
CONFIDENCE

A .01 → → → → → → → → → → .99

B .05 → → → → → → → → → → .95

1

100



Al p h a
Re j e c t s
T_{rue}
Null
Hypothesis

Beta
Accepts
False **N**ull **H**ypothesis

INFERENCEAL STATISTICS

~~Inferenceal statistics are used to make inferences about the larger population and are concerned with generalizing from sample to population.~~

~~I. Level of Significance~~

~~Level of Significance has to do with the researcher's decision of how and/or when to accept or reject the null hypothesis and state that there is or isn't a significant difference. The Level of Significance is most frequently set at .01 or .05 in our field. A .05 level of significance corresponds to a .95 level of confidence. So, both a .05 level of significance AND a .95 level of confidence means that the results of a study would be due to chance only 5 or fewer times out of 100.~~

II. Types of Error

Types of Error are noted by **Type I/Alpha** or **Type II/Beta**. The true status of the null hypothesis is determined.

- A. **Type I/Alpha Error:** A null hypothesis is rejected when no differences exist. Remember, a null hypothesis is stated, "There is no significant difference....." In a Type I or Alpha Error, the researcher says there **is** a significant difference (thereby rejecting the null hypothesis) when there really **isn't** a significant difference. In other words, the researcher rejects the null hypothesis as originally stated when he/she should have accepted it.
- B. **Type II/Beta Error:** A null hypothesis is accepted or retained when differences do exist. Remember, a null hypothesis is stated, "There is no significant difference...." In a Type II or Beta Error, the researcher says there **is no** (significant) difference (thereby accepting the null hypothesis) when there really **is** a significant difference. In other words, the researcher accepts the null hypothesis as originally stated when he/she should have rejected it.

Example: There is no significant difference found between subjects who score on the communication scale with respect to their success in forming friendships as measured by a sociogram.

An **Alpha/Type I Error** would say, "Our research shows that there IS significant difference between subjects." In reality, their research was incorrect and they should have accepted their original null hypothesis as stated.

A **Beta/Type II Error** would say, "We found our null hypothesis to be true as stated. There is no significant difference between subjects." However, their research was incorrect and they should have rejected their null hypothesis saying, "There is significant difference...."

Alpha Error/Beta Error Illustration

Null Hypothesis:

It is not true that there is a difference between the IQ of our 7th graders and the national IQ average of 7th graders of 110.

Since our budget is limited, we test only 500 of the 6,000 7th graders in the school system. If, after evaluating our research, **we decide** that the average IQ of all 6,000 of our 7th graders is **not** 110 —WHEN IN REALITY IT IS— we have made a Type I or Alpha Error. As such, we would reject our null hypothesis even though it is true; i.e. we would say that the IQs of our 7th grades is not 110...when, in reality, it is 110.

However, we can decide to limit our risk of making such a decision by setting our Level of Significance at such a point/value that we would feel confident that our **decision** to reject or accept our null hypothesis was reasonable/based on solid conclusions. The risk of making a Type I/Alpha error is called the level of significance of hypothesis testing. Level of Significance is usually symbolized by the Greek letter alpha (α) — thus the level of significance is sometimes referred to as the Alpha level of a test. You may have read a research report that says their study was “significant at the .05 level.” What that says is that the research was designed such that the risk of making a Type I/Alpha error was set at five percent (5%). Therefore, they have a 95% confidence level in their research.

If we **decided**, after we reviewed and studied our research, that the average IQ of our 7th graders was 110 WHEN IN REALITY IT WAS NOT, we have made a Type II or Beta error. If we decided to agree with our original null hypothesis WHEN WE SHOULDN'T HAVE, we have committed a Type II error. The Greek letter beta (β) is often used to refer to this type of error. So, we would in essence say, “The IQ of our 7th graders is 110 just as the national average of 7th graders.” However, reality would be that our 7th graders do not have an average IQ of 110.

Chapter 4

Appraisal or Assessment

APPRAISAL OR ASSESSMENT TECHNIQUES

NCE – Chapter 4

Chapter Outline

DEFINITION OF APPRAISAL

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- I. Major Ethical Principles
 - A. Best Interest of the Client
 - B. Informed Consent
 - C. Releasing Client Records
 - D. Competence
 - E. Ethical Issues Related to Test Security
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- I. Reliability
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 - 1. Test-Retest
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 - 3. Split-Half Procedures
 - 4. Internal Consistency Procedures (Coefficient Alpha)
 - 5. Inter-Rater Reliability
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- II. Validity
 - A. Face Validity
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- I. Criterion-Referenced vs. Normative-Referenced Tests
- II. Objective vs. Subjective Tests
- III. Individual vs. Group Tests

TYPES OF STANDARDIZED TESTS

- I. Achievement Tests
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- III. Intelligence Tests
- IV. Interests, Attitudes, and Values Tests
- V. Psychopathology Tests
- VI. Personality Tests

REVIEW OF SELECTED INSTRUMENTS

- I. Individual Tests of General Intelligence (IQ Tests)
 - A. The Stanford-Binet Intelligence Scale
 - B. Wechsler Adult Intelligence Scale – III (WAIS-III)
 - Comparison of the WAIS-III and the Stanford-Binet
 - C. Wechsler Intelligence Scale for Children – Third Edition (WISC-III)
 - D. Wechsler Preschool and Primary Scale of Intelligence – Revised (WPPSI-R)
 - E. Otis-Lennon School Ability Test (OLSAT)
 - F. System of Multicultural Pluralistic Assessment (SOMPA)

II. Tests for Special Populations

- A. Tests for Very Young Children
 - 1. Gesell Development Schedules
 - 2. Bayley Scales of Infant Development
 - 3. McCarthy Scales of Children's Abilities
 - 4. Miller Assessment for Preschoolers
- B. The Mentally Retarded
 - 1. Vineland Social Maturity Scale
 - 2. AAMR Adaptive Behavior Scale
 - 3. Columbia Mental Maturity Scale (CMMS)
 - 4. Bruininks-Oseretsky Test of Motor Proficiency
- C. Tests for the Physically Handicapped
 - 1. Hiskey-Nebraska
 - 2. Peabody Picture Vocabulary
- D. Tests for Cultural and Ethnic Minorities
 - 1. Leiter International Performance Scale (LIPS)
 - 2. Culture Fair Intelligence Scale (CFIS) by Cattell
 - 3. Raven's Progressive Matrices

III. Multiple Aptitude Tests

- A. Differential Aptitude Tests, Fifth Edition (DAT)
- B. General Aptitude Test Battery (GATB)

IV. Test of Psychopathology

- A. Adult Psychopathology
 - 1. Minnesota Multiphasic Personality Inventory-II (MMPI-2)
 - 2. Millon Clinical Multiaxial Inventory (MCMI)
- B. Child Psychopathology Measures
 - 1. Personality Inventory for Children (PIC)
 - 2. Multiple Checklists and Rating Scales
 - The Child Behavior Checklist
- C. Tests Used to Screen for Organicity (Detect Brain Damage)
 - Bender Visual Motor Gestalt Test (BGT)
 - Luria-Nebraska Neuropsychological Battery
- D. Tests Used to Detect Learning Disabilities
 - Illinois Test of Psycholinguistic Abilities (ITPA)
 - Porch Index of Communicative Ability in Children (PICAC)
 - Assessment of Basic Competencies (Kaufman ABC)

V. Test of Personality (Nondiagnostic)

- A. California Psychological Inventory (CPI)
- B. Sixteen Personality Factor Questionnaire (16 PF)
- C. Edwards Personal Preference Schedule (EPPS)
- D. Personality Research Form (PRF)

VI. Career and Vocational Testing

- A. Strong Interest Inventory (SII)
- B. Jackson Vocational Interest Survey (JVIS)
- C. Career Assessment Inventory (CAI)
- D. Kuder Preference Record
- E. Self-Directed Search (SDS)

MISCELLANEOUS INFORMATION

- I. Important Test Reference Books by Buros
 - A. Mental Measurement Yearbook
 - B. Tests in Print
- II. Two Types of Thinking
 - A. Divergent
 - B. Convergent
- III. Individual Testing
 - A. Advantages to Individual Testing
 - B. Disadvantages to Individual Testing
- IV. Group Testing
 - A. Advantages to Group Testing
 - B. Disadvantages to Group Testing

APPRAISAL OR ASSESSMENT TECHNIQUES

NCE – Chapter 4

DEFINITION OF APPRAISAL

- I. Appraisal, assessment, and evaluation are all terms that are used within psychology and counseling to refer to the process of determining or estimating the nature or intensity of a variety of attributes, abilities, and behaviors of an individual.
- II. Appraisal processes span a wide variety of specific activities including:
 - clinical interviewing
 - behavioral observation
 - neuropsychological testing
 - career interest and ability measurement
 - occupational assessments
 - academic evaluations
- III. Assessment activities include use of formal, standardized measures as well as informal instruments.
- IV. In counseling settings, the appraisal of client attributes and behaviors plays an important role in assisting clients to achieve goals and to adjust to life circumstances.

ETHICAL ISSUES IN APPRAISAL AND ASSESSMENT TECHNIQUES

I. Major Ethical Principles

A. Best Interest of the Client

1. The purpose of the appraisal is to gather all relevant information about an individual and to do so in a manner that achieves the mutual goals set by the client and the counselor.
2. The counselor must be unbiased and objective in this process; thus, dual roles or multiple relationships with clients are to be avoided.
3. As in all other areas of client-contact, counselors involved in formal appraisal activities must act in the best interest of their clients.

B. Informed Consent

Generally, it is true that counselors do not release information about a client without the express, written consent of the client.

1. **Before beginning the evaluation**, counselors must make sure that clients understand:
 - a. the differences between formal appraisal activities and the counseling process
 - b. that the final product of the appraisal (written report) becomes a permanent document
 - c. the various ways in which this document is going to be used and might (conceivably) be used in the future
 - d. the nature and purpose of the appraisal using terminology the client understands
 - e. how the results of the assessment could or could not affect the client's life
 - f. the conditions under which the client is likely to produce the most accurate or useful results (i.e., being well rested)
2. **After the assessment has been completed**, clients have a right to a formal, face-to-face time of feedback where test results are reviewed and any questions are addressed.

As some clients may be overly impressed or intimidated with assessment findings, counselors must clearly explain results and the limitations of the instruments utilized in the appraisal.

C. Releasing Client Records

- Counselors ensure that records are kept secure and that information is released only to individuals who are qualified to receive it and have been given permission to do so.
- Counselors store client files in secure places (locked) and do not transfer records they have received from other agencies or providers.

D. Competence

Counselors must have the necessary formal education or professional training to utilize the assessment instruments chosen to accomplish an appraisal.

1. Training standards

- a. Although no specific set of standards has been established to ensure that counselors possess adequate preparation to use particular tests, certain guidelines are generally accepted.
- b. These include:
 - receiving professional training on the specific instrument
 - demonstrating knowledge of the licensing standards for the jurisdiction in which the counselor is practicing or planning to practice
 - limiting testing to areas and instruments that the counselor is formally qualified by education, training, or experience
- c. The issue of competence extends to test selection decisions as well.
- d. Counselors should be aware of available tests and be informed about their relative characteristics, strengths, and limitations.
- e. Counselors must also be prepared to communicate their findings to the client and possibly to others such as their family, physician, employer, and the court.

2. Expert Witness Testimony

- a. Counselors conducting appraisals must keep in mind that the report they generate could become a matter of public record in a hearing or trial and that they might be called to account for their statements in court settings such as custody hearings, employment, commitment and competency hearings, criminal trials, and disability determination hearings.
- b. The legal process is often acrimonious, and novice counselors may be unsettled if they are unaware that opposing attorneys will frequently question their credentials, criticize their appraisal process as inadequate, argue for a contradictory position via another expert witness, and/or attempt to have the counselor verbally misstate or directly contradict their written report.
- c. It would be wise for counselors preparing to go to court for the first time in a professional context to go to court and observe other mental health professionals testifying as expert witnesses prior to their own court date.

E. Ethical Issues Related to Test Security

- Counselors have a professional responsibility to protect the security of tests from improper usage, copying, or distribution.
- In addition, most psychological tests require that the subject be unfamiliar with the items; therefore, tests must be stored in a manner to prevent unauthorized access.
- Although many tests can be completed by clients without instruction, it is a good idea to supervise the client as he or she completes the instrument.

II. Multicultural Issues in Testing

- A. Counselors must take care when choosing tests for clients who are ethnic minorities, foreigners, or non-native English speakers.
- Since some of these groups will **not** have been included in the standardization samples on which the test was normed, it may not be an appropriate or interpretable measure for this client.
 - Similarly, counselors should be aware of items on the test which refer to experiences likely to be unfamiliar to certain clients (called “content bias”).
- B. Counselors should also be quite familiar with the legal standards regarding the rights and proper treatment of individuals who are handicapped or otherwise disabled (e.g. the Education for All Handicapped Children Act, 1975 and the Americans with Disabilities Act, 1990).
- C. Counselors should remember that mental disorders are defined in a cultural context, with behavior patterns seeming strange in one setting actually being common or adaptive in another cultural context.

PSYCHOMETRIC FOUNDATIONS OF APPRAISAL

Psychological tests are generally evaluated in terms of reliability, validity, and overall usefulness. While the usefulness consideration is fairly obvious (cost, time, ease of instructions, etc.), the other dimensions merit more careful discussion.

I. Reliability

- Reliability is commonly defined as the consistency of a test or the degree to which it yields the same results in repeated administrations to the same test group.
- Statistically, a test's reliability is expressed as a correlation or reliability coefficient.
- **Reliability coefficients** range from 0.0 to +1.0, with scores of .75 or higher considered strong in most situations.

A. Types of Reliability

1. Test-Retest

- The same subjects are given the same test twice to see if scores are consistent over a specific amount of time (e.g. two weeks).
- This type of reliability controls for the content of the items (makes them identical by giving exactly the same test each time) and can directly measure temporal effects.
- However, if prior exposure to the test is believed to potentially or to probably influence performance, test-retest reliability may be less accurately estimated. This is a potential issue for many measures of personality and psychopathology.

2. Parallel or Alternate Forms

- By varying the items on the instrument, the researcher can directly assess the influence of item content on the consistency of test results.
- In the parallel or the alternate forms approach, two, nearly-identical versions of the instrument are constructed, and the same subjects complete both versions as close together in time as possible.
- Although this approach has a certain appeal, it is less practical since relatively few instruments have pre-existing alternate forms and because conceptually some of the tests that offer parallel forms have failed to demonstrate adequate consistency between test versions.

3. Split-Half Procedures

- The examiner can artificially create parallel forms of a test by splitting the items in half and measuring the consistency of the two halves.
- This approach also directly measures variability due to item content and is less susceptible to the effects of time than the parallel forms method.
- However, deciding how to best split the items can be a matter of some debate and obvious confusion as different “splits” will yield different reliability estimates.
- The Spearman-Brown (Prophecy) Formula is used to calculate a general estimate based on Split-Half procedures (less dependent on the particular split, functioning like an average of the estimates obtained by splitting the items multiple times).
- Be aware, however, that Split-half reliability coefficients are observed to sometimes yield inflated estimates of the reliability of a scale in comparison to other approaches.

4. Internal Consistency Procedures (Coefficient alpha)

- The most popular approach to assessing the reliability of a test currently is the internal consistency method.
- Also known as “coefficient alpha,” this approach directly assess the consistency of the items by comparing each item to the overall test score (actually by calculating a correlation between the score on the item and a corrected total score, achieved by subtracting the item score from the total score before computing the correlation).
- Coefficient Alpha (also known as “Cronbach’s alpha”) may be practically thought of as an overall average of the degree to which the individual items on a test are measuring the construct of interest in a similar manner.
- Technically, the internal consistency approach assesses reliability in terms of the overall homogeneity of the items on the test.
- The Kuder-Richardson procedure is a somewhat similar (and older) method. This method of estimating reliability focuses on complex, statistical computations to determine how all items on the test relate to all other items on the test. Therefore, this is a measure of inter-item consistency.

5. Inter-Rater Reliability

- Also known as **Inter-Scorer or Inter-Observer Reliability**, this general approach calculates the degree to which different raters arrive at similar judgments or frequency counts when observing behavior or assessing an individual via interview or observational methods.
- This type of reliability is important whenever scorer judgment is involved and responses are open to interpretation.
- Each test is scored independently by two or more examiners.

6. Standard Error of Measurement (SEM)

- Standard Error of Measurement is an alternative method to check reliability. Statistically, 68 percent of the time, an examinee's true score would fall within +1 and -1 SEM of his/her obtained score.
- A test with a small SEM has a high **reliability coefficient** (.75 to 1.0). A test with a large SEM has a low **reliability coefficient** (0.0 to .24).

Standard Error of Measurement Illustration

“Standard Error of Measurement” (SEM) is a term used in conjunction with the term “standard deviation” which we have discussed and illustrated in this chapter.

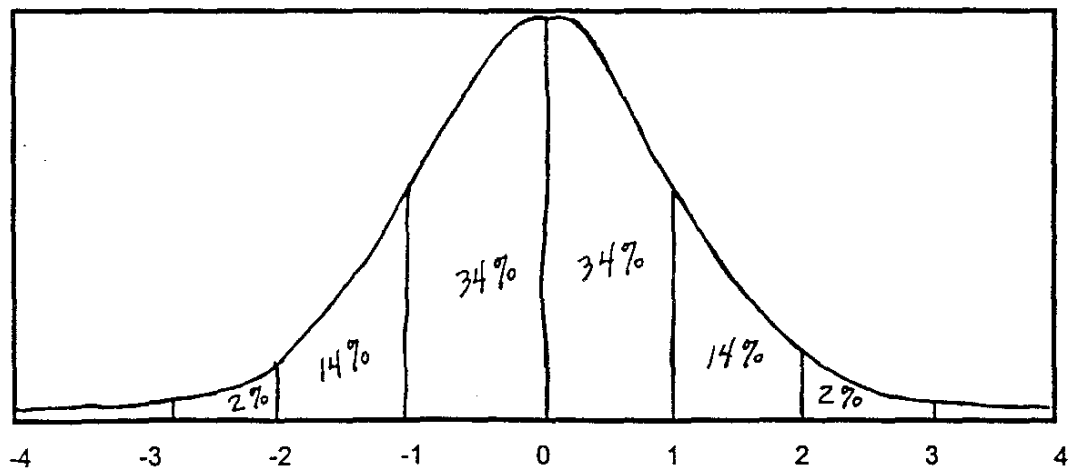
Just as standard deviation is a measure of the variability of scores, the **Standard Error of Measurement** (SEM) indicates the variability of scores a person would attain if they took the exact same test numerous times. Since a person taking the same test over and over would likely NOT get exactly the same score, SEM is a way of measuring the variability of the repeated scores when these scores are plotted on the Bell Curve/Normal Distribution.

Thus, if Merle Brown receives a score of 40 on measure A, and the SEM for this test is 4, we can estimate that we are 68% certain that Merle’s “true” score is between 36 and 44 (40 minus an SEM of 4 = 36OR40 + an SEM of 4 = 44).

We can be 96% certain that his “true” score is between 32 and 48 (40 minus 2 SEMs (4 + 4 = 8) = 40 minus 8 = 32.....OR.....40 + 2 SEMs (4 + 4 = 8) = 40 + 8 = 48).

We would be 100% (99.9% technically) certain that his true score lies between 28 and 52 (40 minus 3 SEMs (4+4+4=12) = 40 minus 12 = 28.....OR....40 + 3 SEMs (4+4+4=12) = 40 + 12 =52).

NOTE WELL: If you were using the more precise values of the percentages under the Bell Curve, your answers would vary.



Merle's score of 40 with a Standard Error of Measurement of 4

28 32 36 40 44 48 52

		34% + 34% = 68%		
		14% + 34% + 34% + 14% = 96%		
		2% + 14% + 34% + 34% + 14% + 2% = 100%		

B. Types of Tests

Some measures of ability, intelligence, and achievement directly employ strategies to make it less likely that individuals will get all the items on the test correct. Obviously, the estimate of reliability obtained would be more difficult to achieve under this scenario. Therefore, two specific types of tests have been developed to address this concern:

1. **Speed Tests** include so many items that no one can complete them in an allotted time (Example: arithmetic portion of the WRAT; Coding or Symbol Search on the WISC and WAIS).
2. **Power Tests** include some very difficult items which few if any subjects are able to answer correctly (Example: the final items on almost any subtest on intelligence and achievement measures).

C. Factors which Affect Reliability

The factors which are known to directly affect the estimated reliability of a test are as follows:

1. **Test length** – a greater number of similar items yields increased reliability estimates
2. **Homogeneity** of the items – greater variety in the content of the items leads to lowered reliability estimates
3. **Test-retest interval** – shorter time intervals lead to higher reliability estimates
4. **Range constriction** – the greater the variance the higher the estimated reliability
5. **Other systematic** (influencing reliability estimates in a specific direction, like guessing and response sets) **and unsystematic** (uncontrolled) **factors** also influence reliability estimates

II. Validity

- The validity of a test is generally defined as the degree to which a test measures what it is supposed to measure. Does the test actually perform acceptably its stated purpose?
- Validity is measured by calculating a **validity coefficient**, which is practically the square of the correlation between the test scores and the criterion score.
- In this instance, it represents a direct measure of the percentage of variance accounted for between the two measures (how much of the change in one of the scores can one predict or explain by knowing the direction and magnitude of change observed on the other measure).

There are four types of test validity:

- Face validity** – Although not technically a type of validity as there is no validity coefficient to calculate, it is a useful idea as it speaks to the degree to which the items on the test appear to measure or to tap the construct of interest. This appearance does not qualify empirically as a measure of validity, but it is probably the most commonly used consideration in determining the counselor's choice of selected instruments for a particular case.
- Content validity** refers to the degree to which a sample of test items adequately represents or covers the content area the test is supposed to measure. The pool of test items should be representative of the behavior or the ability to be measured and should adequately and evenly sample each of the domains of interest. This is of prime importance in achievement tests and is clearly the major issue in all classroom tests.
- Criterion-related validity** determines the extent to which a test can predict, diagnose, or classify an individual's behavior in specific situations. There are three types:
 1. Predictive: Predicts future outcomes
 2. Diagnostic: Tries to diagnose or identify an existing state. The results are compared to a known criterion.
 3. Concurrent – determines how well a test measures what it was designed to measure by comparing performance on the test to an external criterion. This approach is frequently seen in employee selection and appraisal settings where the test has previously demonstrated a strong, positive relationship with the criterion.
- Construct validity** is the extent to which a test measures a concept, construct, or trait of interest. However, here there exists no “real-world,” external criterion of this construct. Therefore, construct validity is a more conceptual or theoretical issue and is difficult to establish quickly. Nevertheless, based on theoretical hypotheses, a number of comparisons can be made and adequately establish this type of validity. These “compare and contrast” calculations are labeled **convergent validity coefficients** and **divergent validity coefficients** (or more often **discriminate validity coefficients**) and over a series of such comparisons construct validity is sufficiently established.

III. Validity and/or Reliability

Although reliability and validity are both essential qualities of a “good” test, there has been much debate about which is most important. Although most authors conclude that without at least some degree of validity the test is useless, the most obvious conclusion is that both properties are necessary. However, this creates an interesting and troublesome paradox as the strategies to directly improve one (adding items of varied content to improve the content validity) will directly decrease our estimate of the other (lowered reliability).

IV. Test Construction Issues

Item analysis is the procedure of evaluating test items. There are two primary methods:

- A. **The Item Difficulty Index** describes the percentage of persons who answer an item correctly.
 - Although unpopular with students and teachers alike, an ideal Item Difficulty Index from a statistical perspective is .50, where half the subjects miss the item.
- B. **The Item Discrimination Index** describes the relative performance of the top and the bottom quarter of the distribution of the class or sample on the item.
 - Four different groups are delineated based on overall test performance (total score), and then the items are reexamined to see how well subjects in the upper and lower quarters of the distribution fared on each item.
 - Items judged to have strong Item Discrimination Indices are those where most of the high performers on the test get the item correct, and a majority of those who did poorly miss the item.
 - Thus, the item “discriminates” well between those scoring highly and those who did not.

RECOMMENDATIONS FOR PROFESSIONAL COUNSELORS INVOLVED IN APPRAISAL ACTIVITIES

- I. If a professional counselor uses a test in their professional activities and find themselves in court (testifying in a case or defending themselves against action taken in part as a result of the test results), they should expect to be called upon to prove their **training** and **competence** in the use of and interpretation of that instrument and to defend the validity and reliability of the instrument itself.

- II. Test Selection Considerations - Before selecting a particular type of testing instrument a number of practical and technical considerations should be made:
 - cost,
 - time limits,
 - ease of administration,
 - format,
 - availability of alternate format,
 - multiple-level exams,
 - availability of answer sheets and simple scoring procedures, and
 - ease of interpretation.

GENERAL APPRAISAL STRATEGIES

I. Criterion-Referenced versus Normative-Referenced Tests

A. Criterion Referenced

The **criterion referenced** assessment compares group or individual performance with a predetermined set of criteria believed to be important or essential (assessment of handwriting, creativity, art, honesty, etc.).

B. Normative Referenced

The **normative referenced** assessment compares individuals with each other and/or groups who took the same test previously. Most current standardized tests and most teacher-made tests are normative referenced.

II. Objective versus Subjective Tests

The objective-subjective distinction in appraisal primarily has to do with the detail required of the examinee to form or create a response.

A. Subjective Tests

Subjective tests require the formation of an answer from a limited or ambiguous stimulus and are, therefore, more difficult to take and to score/grade. However, in many cases, this may produce greater test validity.

B. Objective Tests

Objective tests require subjects to select a single answer out of already provided answers. Objective tests are, therefore, easier to score and demonstrate stronger reliability.

Examples of Subjective and Objective Tests

	Subjective Tests	Objective Tests
Classroom Setting	Essay Fill-in the blank	Multiple Choice True - False
Psychological Measures of Abnormality	Projective Instruments such as the Rorschach Inkblot Test and incomplete sentence forms	MMPI BDI

III. Individual versus Group Tests

A. Individually-Administered Tests

Individually-administered tests have certain advantages and disadvantages.

1. Advantages to Individual Testing

- In individual testing, the clinician can establish greater rapport with and gain a greater understanding of each client.

2. Disadvantages to Individual Testing

- Individual testing is time consuming and expensive.

B. Group Tests

Group tests generally present opposing strengths and weaknesses.

1. Advantages to Group Testing

- Group testing tends toward more objective scoring.
- Norms are better established.
- Group testing is more economical.

2. Disadvantages to Group Testing

- Group testing allows no chance to establish individual rapport.
- The examiner has no way to know what factors may be influencing an individual's answers.
- Group testing is dependent on the reading skills of the examinee.

TYPES OF STANDARDIZED TESTS

- I. **Achievement Tests** – measure the level of acquisition of information (CAT, MET, Iowa).
- II. **Aptitude Tests** – measure the ability to learn (skills) in a specific area or to predict future behaviors (DAT, ACT, SAT, GRE).
- III. **Intelligence Tests** – measure the ability to function in the world and to apply reasoning and verbal ability.
- IV. **Interests, Attitudes, and Values Tests** – measure preferences or interests for a variety of activities or topics.
- V. **Psychopathology Tests** – measure the symptoms presented or reported by a patient or rated by an interviewer.
- VI. **Personality Tests** – measure qualities, traits, or behaviors that characterize a person's individuality.

REVIEW OF SELECTED INSTRUMENTS

I. Individual Tests of General Intelligence (IQ Tests)

Intelligence may be defined as “a person's ability to assimilate factual knowledge, to recall either recent or remote events, to reason logically, to manipulate concepts (either words or numbers), to translate the abstract to the literal ... to analyze and synthesize forms, as well as to deal meaningfully and accurately with problems and priorities deemed important in a particular setting” (Cronbach, 1984).

A. The Stanford-Binet Intelligence Scale – Fifth Edition

1. The Stanford-Binet is the American version of the Binet-Simon, prepared by Terman and revised a number of times. Binet introduced the concept of mental age (MA) which is the average score for a given age.
 - The intelligence quotient (IQ) is determined by a formula giving a ratio between mental age (MA) and chronological age (CA); $IQ = MA \text{ divided by } CA \times 100$.
 - The Stanford-Binet has a mean of 100, a SD of 15 and a SEM of 10.
2. The Stanford-Binet requires a highly trained examiner and usually takes 30-45 minutes to administer.
 - The tests are grouped into age levels ranging from age 2 to superior adult.
 - Theoretically, the highest MA attainable is 22 years, 10 months. The test is strongly weighted with verbal ability.
3. Procedure to administer: The subjects are not given all the test items.
 - The Examiner starts at a level slightly below the expected MA and either works up or down.
 - Basal age = Level at which all test items are passed.
 - Ceiling age = Level at which all test items are failed.

B. Wechsler Adult Intelligence Scale - III (WAIS-III)

1. The WAIS-III is an individually administered measure of a person's capacity for intelligent behavior as part of a cognitive assessment or a general psychological or neuropsychological assessment.
2. WAIS-III Details:
 - a. Ages: 16 - 74 years
 - b. Norms: Deviation IQs — $M = 100$, $SD = 15$
 - c. $SEM = 3$ on full scale
 - d. Working Time: Approximately 75 minutes
 - e. Content: The two scales, Verbal and Performance, can be administered separately or together.
 - The Verbal Scale can be used alone with people who have visual or motor handicaps.
 - The Performance Scale can be used alone with people who cannot understand or manage language.
 - Includes 11 subtests:

6 Verbal Tests

Information
Comprehension
Arithmetic
Similarities
Digit Span
Vocabulary

5 Performance Tests

Picture Completion
Block Design
Picture Arrangement
Object Assembly
Digit Symbol

- **Comparison of the WAIS-III and the Stanford-Binet** indicates that the WAIS has achieved much larger acceptance. However, the Stanford-Binet is more sensitive to lower levels of mental ability (mental age) as is preferred in many State Schools and Rehabilitation settings.

C. Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV)

1. The WISC-IV continues David Wechsler's concept of intelligence as a global but multifaceted entity that can be inferred from a child's performance on a series of tasks.
 - The WISC-IV is valuable for psychoeducational assessment, placement, and planning.
 - It can be utilized to diagnose exceptionality among school-aged children and has a strong place in clinical and neuropsychological assessment and research.
2. WISC-IV Details:
 - a. Ages: 6 years through 16 years, 11 months
 - b. Norms: Scaled scores and IQs by age; M = 100; SD = 15
 - c. Working Time: 50 - 85 minutes depending upon use of supplemental subtests
 - d. Content: There are four scales that comprise Full Scale IQ:

30% VCI – Verbal Comprehension Index

30% PRI – Perceptual Reasoning Index

20% WMI – Working Memory Index

20% PSI – Processing Speed Index

Equals 100% Full Scale IQ

D. Wechsler Preschool and Primary Scale of Intelligence – Third Edition (WPPSI-III)

1. The WPPSI-III is a standardized measure of intellectual abilities of young children.
2. WPPSI-III Details:
 - a. Ages: 3 years to 7 years, 3 months
 - b. Norms: Scaled scores and deviation IQ.
 - c. Scores by age are provided for 17 age groups divided into 3-month intervals.
 - d. $M = 100$; $SD = 15$
 - e. Working Time: Approximately 1 hour, 15 minutes
 - f. Content: Contains 12 subtests and 3 scales: Verbal, Performance, and Full Scale.

E. Otis-Lennon School Ability Test (OLSAT)

The OLSAT is an intelligence test which can be administered to a group. It can be used to determine students who might qualify for gifted and talented programs.

F. System of Multicultural Pluralistic Assessment (SOMPA)

1. Consisting of 9 different measures, the SOMPA is a comprehensive system for assessing a child's cognitive abilities, perceptual-motor abilities, and adaptive behavior. It provides an innovative way of estimating a child's learning potential by taking into account socio-cultural and health factors.
2. SOMPA Details:
 - a. Ages: 5 to 11 years
 - b. Norms: Different for Black, Hispanic, and White children between 5 and 11 years of age
 - c. Working Time: **Parent Interview** – 20 minutes
Examination of child – 60 minutes
 - d. Content: SOMPA consists of 2 major components: Parent Interview
Student Assessment
 - e. Parent Interview - 3:
 - Sociocultural Scales
 - Adaptive Behavior Inventory for Children (ABIC)
 - Health History Inventories
 - f. Student Assessment - 4:
 - Physical Dexterity Tasks
 - Bender Visual Motor Gestalt Test (BGT)
 - Weight by Height, Visual
 - WISC-IV or WPPSI-III

II. Tests for Special Populations

A. Tests for Very Young Children

1. Gesell Development Schedules

- Measures adaptive skills, gross and fine motor skills, language skills, and personal/social skills via examiner observation. It is used with children 4 weeks – 5 years old.
- **Its best use** is to identify early neurological defects and organically caused behavioral problems.

2. Bayley Scales of Infant Development

- a. Assesses mental, motor, and behavioral development and may be used for:
 - assessing the developmental progress of a child
 - comparing a child's development to that of peers
 - providing an objective basis for deciding a child's eligibility to receive special services
 - demonstrating the effectiveness of intervention and/or remediation services
- b. This test is used with children 2 months to 30 months of age.

3. McCarthy Scales of Children's Abilities

- a. Measures the cognitive and motor development of children ages 2.6 to 8.6 years of age.
- b. This test is composed of 6 subscales:
 - Verbal Scale
 - Perceptual-Performance Scale
 - Quantitative Scale
 - General Cognitive Scale
 - Memory Scale
 - Motor Scale

4. Miller Assessment for Preschoolers

- a. Identifies preschool children with mild to moderate developmental delays.
- b. The developmental domains assessed include:
 - neural foundations
 - coordination
 - verbal and nonverbal cognition
 - the ability to perform complex tasks

B. The Mentally Retarded

The usage of tests for the mentally retarded has **increased greatly** since 1975, **due to the Education for All Handicapped Children's Act**; Public Law 94.142; abbreviated as PL 94.142.....now known as the **Individuals with Disabilities Education Act (IDEA)**.

1. Vineland Social Maturity Scale

- Assesses an individual's competency in taking personal responsibility and in seeing to practical needs.
- Adaptive functioning and social maturity are measured.

2. AAMR Adaptive Behavior Scale

- Is used for children and adults as a behavior rating scale for the mentally retarded, emotionally maladjusted, developmentally disabled, and other handicapped persons.
- It provides objective descriptions and evaluations of an individual's adaptive behavior.

3. Columbia Mental Maturity Scale (CMMS)

- Is an individually administered mental-ability test that requires no verbal response and a minimum of motor response on the child's part.
- It is particularly suitable for use with children who are entering nursery school or kindergarten, or with children with impaired physical or verbal functioning.

4. Bruininks-Oseretsky Test of Motor Proficiency

- Tests gross and fine motor skills for subjects' ages 4.5 to 14.5 years of age.
- It has high reliability and validity and is widely used.

C. Tests for the Physically Handicapped

1. Hiskey-Nebraska

- Assesses hearing-impaired children ages 3 to 16 years of age.
- It contains 12 subtests.

2. Peabody Picture Vocabulary

- Is for use with the severely handicapped, ages 2.5 to 18 years of age.
- This instrument contains 150 plates containing 4 pictures.
- An examiner calls out a word, and the examinee points to the corresponding picture.
- Raw scores are converted to mental age scores.
- Norms: Deviation IQ percentiles.

D. Tests for Cultural and Ethnic Minorities

1. Leiter International Performance Scale (LIPS)

- The LIPS is a very complicated test requiring a highly proficient examiner.
- It is used with those ages 2 – 18 and yields mental age scores and ratio IQs.
- This test has the distinct feature of eliminating instructions.

2. Culture Fair Intelligence Scale (CFIS) by Cattell

- a. The CFIS is a paper and pencil test separated for three age levels:
 - ages 4-8 and MR
 - ages 8-13 and average adult
 - ages 10-16 and superior adult
- b. This is a highly speeded test with extensive instructions.

3. Raven's Progressive Matrices

- Progressive Matrices assess general intelligence for those ages 8 – 65.
- This non-verbal intelligence test consists of designs/matrices. In each design, a piece has been left out. The test-taker is asked to select the missing piece from alternatives available to him/her.

III. Multiple Aptitude Tests

- Multiple Aptitude Tests developed out of a need to know more about differential aptitudes.
- There is no agreement over what the factors are that make up general intelligence.
- The statistical technique of factor analysis is used to construct multiple aptitude batteries.
- The most widely used multiple aptitude tests are:
 - A. **Differential Aptitude Tests, Fifth Edition (DAT)**
 1. The DAT features two levels that collectively measure aptitudes of students in grades 7 through 12, as well as adults.
 2. This battery of tests is designed to measure a student's ability to learn or to succeed in a number of different areas, such as verbal reasoning, language usage, numerical reasoning, mechanical reasoning, and space relations.
 - B. **General Aptitude Test Battery (GATB) (written by Frank Parsons)**
 1. The GATB was developed by the U.S. Employment Service for use in state employment services and the military to measure 9 factors and assess performance.
 2. It is validated against occupational criteria.

IV. Tests of Psychopathology

A. Adult Psychopathology

1. Minnesota Multiphasic Personality Inventory-II (MMPI-2)

- Validity and clinical scales empirically derived from patient and nonpatient samples on pathological groups.
- Interpretation is primarily based on T-distribution elevations (T=65 or above; M = 50, SD = 10).
- Here are the abbreviations and names of the scales followed by behaviors associated with elevated scores:

Validity Scales

- a. L (Lie Score)
 - Selecting an overly large percentage of “unusual” or infrequent responses.
 - Suggests that the inventory may have been completed randomly or incorrectly.
- b. F (Fake Bad)
 - Measures the degree to which an examinee is willing to report psychological symptoms.
 - Both extremely high and very low scores can indicate a validity concern in this area.
- c. K (Defensiveness)
 - Measures guardedness or hesitation to acknowledge psychological symptoms.
- d. VRIN and TRIN
 - Additional scales added on the MMPI-2 to assess more subtle response biases, including a number of items which are answered twice. The responses are manually viewed for consistency.

Clinical Scales – 10

1. HS (Hypochondriasis) – Physical complaints; weakness.
2. DE (Depression) – Worry; discouragement; hopelessness.
3. HY (Hysteria) – Specific somatic complaints or happy acceptance of things in general (denial).
4. PD (Psychopathic Deviate) – Asocial behaviors characterized by interpersonal withdrawal.
5. MF (Masculinity-Femininity)
Male: Cultural-aesthetic interests; passivity; academic achievement.
Female: Outdoor-mechanical interests; competition.
6. PA (Paranoia) – Easily hurt; complaints of persecution; suspiciousness.
7. PT (Psychasthenia) – Narcissism; magical thinking; sadomasochistic tendencies; anxiety; self-concern; self-doubt.
8. SC (Schizophrenia) – Social and family alienation; bizarre emotions; delusions; somatic symptoms; influence of external agents; peculiar bodily dysfunction; dissatisfaction; depression.
9. MA (Hypomania) – Expansiveness, egotism, and irritability.
10. SI (Social Introversion) – Lack of confidence; worry; interpersonal anxiety.

2. Millon Clinical Multiaxial Inventory (MCMI)

- The MCMI is a self-report inventory designed for clinical adults at least 18 years old.
- The MCMI has clinical scales which allow for differential diagnosis and is coordinated with DSM-IV diagnostic categories.

B. Child Psychopathology Measures

1. Personality Inventory for Children (PIC)

- The PIC was developed via the same methodology as the MMPI/CPI, but it does not use MMPI items.
 - Used for ages 6–16, the PIC is an inventory of observed behavior utilizing informants.
2. Multiple checklists and rating scales are also utilized to assess childhood psychiatric symptomatology.
- **The Child Behavior Checklist (Achenbach)** is one of the best known of these tests.

C. Tests Used to Screen for Organicity (Detect Brain Damage)

1. A number of measures are used within Clinical Psychology and Neuropsychology to screen for organic or neurological damage, including the Mini-Mental Status Exam, the Quick Neuropsychology Screening Test, and the Cognistat.

2. More popular measures are listed below:

a. Bender Visual Motor Gestalt Test (BGT)

The BGT is a valuable diagnostic tool and a widely used research instrument.

The test is useful in assessing the maturation of visual motor gestalt function in children and for exploring retardation, regression, loss of function, organic brain defects, and personality deviations in both adults and children.

b. Luria-Nebraska Neuropsychological Battery

D. Tests Used to Detect Learning Disabilities

1. **Learning disabilities** are serious problems with one or more educational skills being dysfunctional, combined with normal or above intelligence.

2. The skills most affected are usually reading and language development.

a. Illinois Test of Psycholinguistic Abilities (ITPA)

The ITPA is a very difficult test to give and requires extensive training and experience by the examiner.

It is specifically designed to assess psycholinguistic abilities and disabilities of handicapped children ages 2 – 10 years.

b. Porch Index of Communicative Ability in Children (PICAC)

c. Assessment of Basic Competencies (Kaufman ABC)

V. Tests of Personality (Nondiagnostic)

A. California Psychological Inventory (CPI)

- The CPI consists of 480 items, half drawn from the MMPI.
- It is designed for use with "normal" populations ages 13 and over and has 18 scales on such personality dimensions as responsibility, dominance, sociability, self-acceptance, etc.

B. Sixteen Personality Factor Questionnaire (16 PF)

- The 16 PF was developed by Cattell using factor analysis to classify personality traits.
- It is designed for the normal population 16 years old and older.
- A low literate edition is available for the disadvantaged.

C. Edwards Personal Preference Schedule (EPPS)

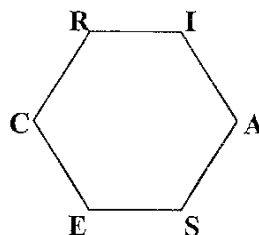
- The EPPS is based on Murray's manifest need system.
- Examinees are given pairs of statements and are asked to choose which one is most characteristic of them.
- This test is for those 18 years old and older and assesses the relative strength of 15 key personal needs and motives.

D. Personality Research Form (PRF)

- The PRF is based on Murray's manifest needs system and uses many of the same scales as Edwards, plus several additional scales.
- It is used with those ages 6 years and older.

VI. Career and Vocational Testing

1. The SII uses Holland's scheme to derive 6 general occupational themes that are always listed in this order: R I A S E C



Following are the general occupational themes and the characteristics each indicates:

- **Realistic** – Deals with the environment in a concrete, objective, and physically manipulative manner; uses minimal interpersonal skills.
 - **Investigative** – Uses intelligence, ideas, words, and symbols to deal with the environment.
 - **Artistic** – Creates art forms; prefers musical, artistic, literary, and dramatic vocations.
 - **Social** – Handles the environment by using people skills and has much concern for human welfare.
 - **Enterprising** – Has adventurous, dominant, enthusiastic, and impulsive qualities; usually prefers sales, supervisory, and leadership vocations.
 - **Conventional** – Chooses goals and activities that have high social approval; prefers clerical and computational tasks; identifies with business and values economic matters.
2. The SII employs two (2) administrative indexes to detect carelessness and test-taking response sets.
 3. The SII has two (2) special scales:
 - Academic Orientation: Used to predict a tendency to continue education through high school, college, graduate school, etc
 - Introversion-Extroversion: Used to reflect interest in working alone or with people.
 4. The SII uses male and female norms.
 5. People tend to get highest scores on adjacent points on the hexagon.

B. Jackson Vocational Interest Survey (JVIS)

The JVIS is a newer test based on 2 constructs:

- Work roles: What a person does on the job
- Work styles: Working styles such as independence, good planning skills, dominant leadership, etc.

C. Career Assessment Inventory (CAI)

1. The CAI is patterned after the Strong Interest Inventory and is for persons seeking a career that does not require a college degree or advanced professional training.
2. However, it can be used for those who are interested in careers requiring up to 4 years in college.
 - The CAI has 370 items at the 8.0 GE reading level.
 - The vocational version is at the 6.0 GE reading level for skilled trades focus.

D. Kuder Preference Record

- The Kuder Preference Record uses a forced choice triad.
- Three (3) activities are listed; the person chooses which activity he/she would like least and most.
- This test can be used with younger examinees and with adults who are poor readers.

E. Self-Directed Search (SDS)

- The SDS was developed by Holland and is self-administered, self-scored, and self-interpreted via a structured process.

MISCELLANEOUS INFORMATION

I. Important Test Reference Books by John Buros

- A. *Mental Measurement Yearbook*
- B. *Tests in Print*

II. Two Types of Thinking

- A. **Divergent** (no limit, infinite)
- B. **Convergent** (logical, progressive, theories)

III. Individual Testing

A. Advantages to Individual Testing

- In individual testing the clinician can establish some rapport with and gain a greater understanding of each client.

B. Disadvantages to Individual Testing

- Individual testing is time consuming and expensive.

IV. Group Testing

A. Advantages to Group Testing

- Group testing tends toward more objective scoring.
- Norms are better established.
- Group testing is more economical.

B. Disadvantages to Group Testing

- Group testing allows no chance to establish individual rapport.
- The examiner has no way to know what factors may be influencing an individual's answers.
- Group testing is dependent on the reading skills of the examinee.

SII and SDS

Person #1

R -4

I - 5

A - 9 = _ _ _ = Differentiated

S - 11

E - 10

C - 7

Person #2

R - 10

I - 11

A - 12 = _ _ _ = Undifferentiated

S - 11

E - 10

C - 11

An **SEA** in an **SEA** work setting = Congruent

An **SEA** in an **SEA** work setting = Low Burnout

An **SEA** in a **CRI** work setting = Incongruent

An **SEA** in a **CRI** work setting = High Burnout

Chapter 5

Counseling Theories, Methods, & Techniques

COUNSELING THEORIES, METHODS, and TECHNIQUES

NCE - Chapter 5

Chapter Outline

THE HELPING PROFESSIONAL

- I. Hazards of the Helping Professional
- II. Skilled Counselors vs. Poor Practitioners
- III. Core Dimensions
- IV. Gazda's Global Scale for Rating Helper Responses
- V. Carkhuff's Scale for Assessing Facilitative Interpersonal Counseling
- VI. Ivey & Authier's Microcounseling Skills Approach
 - A. Ivey & Authier's Microcounseling Skills
 - B. Responses Which Encourage Understanding, Exploration, Solving Problems

The Counseling Models Covered in This Chapter are:

- | | |
|---|-------------------------------------|
| • Psychoanalytic Therapy | • Behavioral Therapy |
| • Adlerian Therapy/Individual Psychology | • Rational Emotive Behavior Therapy |
| • Other Neo-Freudians or Psychodynamic Analysts | • Cognitive Therapy |
| • Existential/Humanistic Therapy | • Reality Therapy |
| • Person-Centered Therapy | • Eclectic Therapy |
| • Gestalt Therapy | • Feminist or Gender-Fair Therapy |
| • Transactional Analysis | • Neuro-Linguistic Programming |

For each of these models, information is arranged under these headings:

- I. Major Figure(s)
- II. Overview
- III. Goals of Treatment
- IV. Role of the Counselor
- V. Normal Development
- VI. Development of Behavioral Disorders
- VII. Applications
- VIII. Suitability in Multicultural Counseling
- IX. Key Concepts and Terminology
- X. Techniques
- XI. Criticisms
- XII. Additional Information

ADDITIONAL MISCELLANEOUS INFORMATION

Psychoanalytic Therapy — Freud

Adlerian Therapy / Individual Therapy — Adler
Dreikers
Dinkmeyer

Other Neo-Freudians or Psychodynamic Analysts

1. Jung
2. Fromm
3. Rank
4. Erikson
5. Sullivan
6. Horney

Existential/Humanistic Therapy
Maslow
May
Frankl

Person-Centered Therapy — Rogers

Gestalt Therapy — Perls

Transactional Analysis — Berne

Behavioral Therapy:

Classical Conditioning Respondent Conditioning	Operant Conditioning Instrumental Learning	Vicarious Conditioning Social Learning Theory
Ivan Pavlov	B.F. Skinner	Albert Bandura & Richard Walters
Joseph Wolpe	David Premack	Julian Rotter
William H. Masters & Virginia Johnson	Neal Miller	John Dollard & Neal Miller
Andrew Salter	Edmund Jacobson	George Kelly
Hans Selye		

Rational Emotive Behavior Therapy — Ellis

Cognitive Therapy — Beck
Meichenbaum

Reality Therapy — Glasser

Eclectic Thorne
Lazarus
Allport

Feminist or Gender-Fair Therapy

Neuro-Linguistic Programming — Bandler and Grinder

THIS MATERIAL IS NOT TESTABLE - JUST FYI

Summary of Historical Figures in Therapeutic Counseling

1900 Ivan Pavlov	Described behavioral theory of conditioned reflexes
1900 Sigmund Freud	Invented first systematic form of therapeutic counseling
1905 Alfred Binet	Invented first intelligence test
1910 Frank Parsons	Established field of vocational guidance
1911 Adler left Freud	Adler left Freud
1920 Carl Jung	Proposed theory of collective unconscious
1920 Alfred Adler	Authored theory of individual psychology
1920 Jacob Moreno	Invented psychodrama
1920 John Watson	Propounded behavioristic notions of prediction and control of behavior
1930 Robert Hoppock	Studied levels of job satisfaction
1940 B.F. Skinner	Formulated theory of operant conditioning
1940 E.G. Williamson	Published standard text on school counseling
1945 Gregory Bateson	Emphasized family influences in psychological disturbances
1945 Kurt Lewin	Used training-group format for personal development
1950 Erik Erikson	Proposed theory of personality development
1950 Jean Piaget	Proposed theory of cognitive development
1950 Victor Frankl	Introduced system of existential therapy
1950 Milton Erickson	Focused on linguistic aspects of therapeutic encounter
1950 Carl Rogers	Proposed theory of non-directive-counseling
1955 Abraham Maslow	Studied self-actualized people
1955 Donald Super	Introduced theory of vocational decision making
1960 Joseph Wolpe	Devised systematic theory of behavior therapy
1960 Jay Haley	Began strategic family therapy
1960 Eric Berne	Introduced transactional analysis (TA)
1960 Albert Ellis	Began rational-emotive therapy (RET)
1960 Albert Bandura	Researched modeling processes in change
1960 Frederick Thorne	Made systematic attempt to create an eclectic system
1965 Fritz Perls	Populized Gestalt therapy
1965 Robert Carkhuff	Organized the skills of helping
1965 Lawrence Kohlberg	Proposed theory of moral development
1965 Jane Loevinger	Proposed theory of ego development
1965 John Krumboltz	Published theory of behavioral counseling
1965 Salvador Minuchin	Developed structural family therapy
1965 Murray Bowen	Brought attention to family-of-origin issues
1965 Virginia Satir	Described communication theory in family therapy
1970 Heinz Kohut	Developed theory of self psychology
1970 Aaron Beck	Refined methods of cognitive therapy
1970 Jerome Frank	Authored seminal work on persuasion in healing
1970 Allen Ivey	Developed microcounseling as an innovation for training counselors
1975 Allan Bergin	Edited first comprehensive research handbook on psychotherapy
1975 Arnold Lazarus	Proposed integrative multimodal treatment approach
1975 Helen Kaplan	Published classic work on sex counseling
1975 Irving Yalom	Refined practice of group treatment
1979 Richard Bandler	Created neurolinguistic programming model of counseling
John Grinder	
1980 Paul Pederson	Championed cause of multicultural awareness in counseling
1980 John Norcross	Represented new movement toward integration of theories

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COUNSELING THEORIES, METHODS, & TECHNIQUES

TEXAS – Chapter 5

THE HELPING PROFESSIONAL

Until about one hundred years ago, the important problems for humans involved manipulating the environment to provide food, clothing, shelter, and protection from danger. Then industrial technology and expanded energy sources allowed us to gain control over the earth's resources to the extent that our physical problems are solved or at least solvable.

Problems still exist though, but now these problems are people problems. We have become so interdependent that few of us could exist for very long without being in contact with others. We are faced with learning how to grow as individuals and with how to interact successfully with others. Positive, productive actions by others seem to be readily accepted. The errors of others, however, can endanger us and those around us. While hostage situations, shootings, abusive actions, the threats of mass destruction by way of nuclear or biological warfare, etc. have become commonplace in the news and affect thousands, many of our greatest problems, in reality, still stem from our relationships with those around us at work, in school, and in our families. This trend will continue according to the futurists who ascertain that with every advancing technological and scientific stage, we become increasingly interdependent and must rely on one another to act cooperatively and responsibly.

In response to this climate, the role of professional helpers has evolved from a rehabilitative emphasis to a preventive focus to the current shift of helping individuals toward self-actualization in the multifaceted situations individuals interact. Flexibility and broadening of counselor skills are required because:

- Definitions of health and well-being are being revised to include the physical–mental link.
- Group-process thinking and techniques have been adopted in classroom instruction for all ages of students.
- Stress management, sensitivity awareness, and consciousness-expanding experiences are sought out in continuing education settings.
- The auto industry, as well as others, is discovering that competing successfully with foreign competitors requires thinking differently.

The list of opportunities for the professional counselor goes on and on as the numbers of potential clientele expand greatly.

In broad terms, the history of counseling can be summarized in this manner:

- The 1950s saw counseling, not testing, become the primary guidance function.
- The 1960s gave rise to the variety of competing psychotherapies.
- The 1970s ushered in crisis hotlines, biofeedback, and behavior modification.
- The 1980s saw counseling become a profession with licensing and professional affiliations.
- The 1990s produced more literature on psychiatric and counseling research and issues than all previous writings put together. With such writings have come a greater understanding of the benefits of concomitant pharmacological interventions with some disorders (i.e. obsessive-compulsive disorder). Various anxiety and personality disorders have replaced what was called *neurosis*. Other diagnoses have been added to the vocabulary (i.e. posttraumatic stress disorder, seasonal affective disorders, and attention deficit disorder).

I. Hazards of the Helping Professional

Helping is not without its hazards. The professional counselor does him/herself a disservice by not having an awareness of and dealing with the following factors:

- A. **Unpredictable financial support** – Financial remuneration can be affected by economic ups and downs as well as perceptions of the worth of the service rendered. The changing health insurance industry has yet to make mental and emotional health a priority.
- B. **Burnout or workaholic tendencies** – The helping professions are not easy and result in statistically high suicide rates. Most counselors enter the profession with a sincere desire to help, and many end up overwhelmed with the unceasing, never-ending demands of clients, students, or patients. Helping people confront their problems and discover appropriate solutions must be accomplished without letting the pain of others drag the counselor down.
- C. **No finished projects** – Growth and improvement take time. A counselor is rarely around to see the end result. Often, all a counselor can do is point a person in the right direction. Not seeing a complete, satisfying end can cause frustration.
- D. **Society's perception of counselors** – Counselors may have trouble just relaxing and being themselves in social settings once other people learn of their profession. Two reactions are typical: First, people may expect counselors to give advice or diagnose problems even at social events. Counselors have watched people become indignant when they respond to requests for advice with the suggestion to make an appointment. Additionally, other people may be intimidated or become defensive when they learn their conversation partner is a counselor. Stories abound of folks who literally stiffen and shrink back when they realize they have been chatting with a counselor.
- E. **One size does not fit all** - Individual differences, cultural differences, family makeup, economic status, etc. all impact people's lives and, therefore, require varying responses from the counselor. No precise words or methods can be applied in each case, and the counselor's response must be fashioned or invented for each situation.
- F. **Ambiguous foundation** – The social sciences are evolving as research elucidates the maybes, buts, ifs, and possibilities of the interactions of humans. Even some "facts" of the 1950s have become "myths" of today, so counselors must be satisfied with basing their professional decisions on the best information available at any given time.

II. Skilled Counselors vs. Poor Practitioners

Studies have shown that clear differences exist between skilled counselors and poor practitioners in the counseling profession. In a nutshell, just as clients behave according to what they believe, counselors interact in the counseling relationship based on their personal belief systems. Significant areas of counselor belief are listed below:

- A. Skilled counselors strive to discover how things look to the clients. The clichés of “seeing through their eyes” “or walking in their shoes” take on realistic meaning. This phenomenological view is what sensitivity and empathy are made of.
- B. Skilled counselors generally believe that people have the capacity to deal effectively with the problems in their lives, and they expect their clients to do so. This positive view of people is conveyed through the message not the methods used or not used.
- C. Skilled counselors have a positive self-concept which translates into confidence, assurance, and personal security. These characteristics are not techniques, but rather are the foundations on which the skilled counselor deals with the world and its problems.
- D. Skilled counselors focus on broadening the perspectives of their clients, tend to project larger holistic goals, and recognize and communicate what is truly significant. Facilitating, encouraging, aiding, and assisting are key tools and activities that contradict directing and controlling activities with their attendant convincing, persuading, and manipulative characteristics. “Big picture” goals are encouraged. Important issues are tackled so that true progress can be made.
- E. Skilled counselors are authentic. They are willing and able to reveal and share themselves and their understanding with their clients. Success is not a result of a particular method since methods are unique and tied to the situation in which they are used. The sincerity, honesty, and clarity of purpose of the counselor takes precedence over the method chosen.

III. Core Dimensions

Research by Carkhuff, Truax, and Mitchell demonstrated that effective counselors have particular, distinctive qualities which the profession has termed *core dimensions*.

Truax and Mitchell identified three core qualities:

- authenticity/genuineness
- positive regard/acceptance
- accurate empathic understanding

Such research spurred Carkhuff to create the counselor effectiveness scales to help quantify these qualities.

Mention should also be made that the literature will sometimes differentiate these three qualities of genuineness, positive regard, and accurate empathy as a *human relations core* since these qualities are directed at the client and impact the relationship with the client.

Additionally, the qualities of expertise, attractiveness, and trustworthiness are termed the *social influence core* since these qualities are perceptions or conclusions arrived at by the client and directed toward the counselor. They indicate the social acceptability of the counselor to the client even if the perception is erroneous, i.e. the wall full of diplomas leads the client to feel the counselor is an expert whether the counselor is competent or not. Sometimes a client will perceive a counselor's similar background as attractive and, therefore, be open to receiving the counselor's help.

IV. Gazda's Global Scale for Rating Helper Responses

George Gazda (1999) created a *Global Scale for Rating Helper Responses* which roughly parallels Carkhuff's levels of facilitative behavior with:

- **A Level One Response** giving no help to the client at all
- **A Level Two Response** being strictly superficial
- **A Level Three Response** facilitating growth but only minimally since the counselor's responses are at least not distorted though only surface
- **A Level Four** (Gazda's highest level) **Response** which entails the counselor's going beyond reflection to underlying feelings and meanings

V. Carkhuff's Scale for Assessing Facilitative Interpersonal Counseling

Robert Carkhuff is recognized for his formulation of a 5-point scale which helps measure facilitative qualities demonstrated by counselors. On Carkhuff's scale, a 5 indicates the highest quality level possible. A score of 3 is the minimum acceptable level.

Carkhuff (1969) examined these major facilitative qualities:

- A. **Empathy:** A true empathic response communicates a depth and clarity of understanding of the client's situation so that the client can clarify and expand his own self-understanding and the understanding of others.

Communicating accurate **empathy** requires

- Intensely concentrating on the client's verbal and non-verbal communication.
- Responding as an interchange with the client.
- Responding with language attuned to the client.
- Responding with a tone similar to that of the client.
- Responding readily and actively.
- Moving tentatively toward expanding the client's understanding to higher levels.
- Concentrating on what the client is not saying.
- Judging the effectiveness of the responses by the client's behavior.

Empathy, by far, is viewed by educators of counselors to be the most impacting factor in the counselor-client relationship.

- B. **Respect:** The communication of respect lays a foundation of trust and confidence from which the client can explore concerns. This foundation also fosters a client's own self-respect and a respect for others.

Communicating **respect** requires

- Suspending all critical judgments of the client.
- Speaking with warm and modulated tones, even if minimally so.
- Focusing on understanding the client.
- Providing the client adequate opportunities to self-disclose knowledge that would engender further positive regard from the counselor.
- Communicating spontaneously and genuinely.

- C. **Concreteness:** The communication of concreteness prepares a client to specifically address relevant issues both within and outside of therapy.

Communicating **concreteness** requires

- Making concrete reflections and interpretations.
- Assigning value to the client's communications.
- Determining the necessity and appropriateness of a client's making concrete or non-concrete observations.

- D. **Genuineness and Self-Disclosure:** Genuineness and self-disclosure are complementary and reveal the true purpose of the counseling interchange as helping.

Communicating **genuineness and self-disclosure** requires

- Minimizing the effects of the counselor's profession, role, etc.
- Responding authentically.
- Welcoming encouraging authentic responses from the client.
- Purposefully increasing the openness and freedom within the helping relationship.
- Fully sharing experiences with the client.
- Progressively delving into difficult areas of the counselor's own experience.
- Using the counselor's own experience as the best guideline.

- E. **Confrontation:** Clients can only confront themselves and others appropriately if discrepancies in their behaviors are first confronted. Such discrepancies encompass:

- a. how clients express who or what they want to be versus how they actually experience themselves;
- b. how clients verbally express their awareness of themselves versus observable and reported behavior; and
- c. how the counselor experiences clients versus the clients' expression of their experiences.

Effective **confrontation** responses require

- Concentrating on the client's verbal and non-verbal expression.
- Questioning discrepant communication.
- Questioning discrepant behavior.

- F. **Immediacy:** The counselor-client interchange is evaluated in the here and now. The counselor is actively determining what the client is trying to communicate even if the client is not communicating in a direct manner.

Communicating **immediacy** requires

- Concentrating on the immediate experience with the client.
- Sometimes disregarding the content of the client's communication in an attempt to discern what the client is really trying to say.
- Turning seemingly directionless moments to the question of immediacy.
- Purposefully applying the question of immediacy on a periodic basis.

VI. Ivey and Authier's Microcounseling Skills Approach

Allen Ivey and Jerry Authier (1978) formulated one of the first communications skills models to be applied to the counseling profession. They proposed that raising the levels of effective communication in professionals would raise the competency of counselors and thereby lessen the use of labeling, stereotyping, and dominating techniques.

A. Ivey and Authier's Microcounseling Skills

Ivey and Authier's microcounseling skills include the following (Axelson, 1999):

1. Fundamental attending and self-expression skills (both verbal and nonverbal)
2. Qualitative dimensions that provide the foundation for attending – Concreteness, immediacy, respect, confrontation, genuineness, and positive regard
3. Microtraining skills that help lead the client
4. Attending skills – closed and open questions, paraphrasing, summarizing, reflection, encouragement, etc.
5. Influencing skills – interpretation, directives, expressing content, influencing summary, etc.
6. Focus dimensions that pinpoint the target content – Others, the client, a topic, the counselor, direct mutual communication, cultural or environmental context

B. Responses which Encourage Understanding, Exploration, and Solving Problems

The following responses are considered to be productive responses for counselors to employ. These responses encourage understanding, exploration, and solving problems regardless of the basic theoretical model being used by the counselor.

1. Attending – paying attention, eye contact, sitting forward, etc.
2. Reflection – restating the emotional component of the client's communication.
Common reflection errors include:
 - Reading more or less into the client's communication than is there.
 - Using inappropriate language for the client (wrong cultural reference or education level)
 - Beginning every response in the same manner
 - Using poor timing (reflecting every statement or waiting too long to respond)
3. Paraphrasing – restating the content of the client's communication
4. Leading – direct or indirect encouraging to talk further
5. Summarizing – distilling and expressing the theme or topic of the client's communication
6. Clarification – clearing up ambiguities, inclusive terms, double meanings, etc.
7. Support – expressing that the client has been heard or understood
8. Confrontation – questioning discrepancies, conflicts, mixed messages, etc.
9. Approval – agreeing with the client's ideas, behaviors, or feelings
10. Interpreting – positing meaning for implicit messages from the client's communication
11. Instructing – teaching appropriate responses for specific situations
12. Information giving – providing information so the client can make decisions, consider alternatives, etc.
13. Homework – assigning tasks to be done outside of sessions
14. Contracting – formal or informal commitment

PSYCHOANALYTIC THERAPY

I. Major Figure

Sigmund Freud

II. Overview of the Psychoanalytic Model

- A. Sigmund Freud learned the “talking cure” (his cathartic method) from Jean-Martin Charcot and Josef Breuer. He went on to theorize the personality structure of the id, ego, and superego as well as the existence of an unconscious mind which resides under or behind the conscious and preconscious minds. Thus, Freud is credited with formulating the first counseling model.
- B. The psychoanalytic counselor concentrates on:
 - 1. The client’s past history, especially early childhood events
 - 2. The inter-relationship of the parts of the client’s personality
 - 3. The relationship between the counselor and the client

III. Goals of Psychoanalytic Treatment

- A. Bring the client’s unconscious to the conscious
- B. Help the client work through repressed conflicts
- C. Help the client reach intellectual awareness
- D. Help the client restructure his or her basic personality

IV. Role of the Psychoanalytic Counselor

- A. The counselor is an anonymous expert and makes interpretations of the meaning of current behavior as the behavior relates to the past.
- B. The client is encouraged to develop projections toward the counselor.
- C. The counselor assists with reducing any resistances that develop as the client works with transferences.

V. Normal Development

Successfully resolving and integrating the psychosexual stages of development leads to normal personality development.

VI. Development of Behavioral Disorders

- A. Personality flaws result from the failure to successfully resolve conflicts at an earlier stage of ego development.
- B. Anxiety occurs when basic conflicts are repressed.

VII. Applications of the Psychoanalytic Model

- A. Suitable for:
 - Individuals
 - Groups
 - Those in pain
 - Those who have received intensive therapy and want to progress further
 - Those who want to become counselors
- B. Not suitable for:
 - Self-centered clients
 - Impulsive clients
 - Severely impaired psychotics

VIII. Suitability of the Psychoanalytic Model in Multicultural Counseling

- A. Focusing on family relationships and early childhood conflicts is applicable to many minority groups.
- B. Clients wanting professional distance appreciate the counselor's formality.
- C. The concept of ego defense mechanisms is helpful in explaining personal inner workings as well as relationships to external (environmental) stresses.
- D. Clients wanting to learn coping skills for the daily pressures of living will not endure the in-depth, time-consuming, long-term treatment.
- E. Some cultures emphasize interpersonal and environmental influences as opposed to the internal focus of psychoanalytic counseling.

IX. Key Psychoanalytic Concepts and Terminology

A. Freud's Structure of Personality

ID – is the original system of personality and the primary source of psychic energy and the seat of instincts. It is the seat of the libido and is ruled by the pleasure principle. The id has no sense of time, never matures, and is chaotic.

EGO – functions to contact the real world. It balances (similar to the fulcrum of a see-saw) between the impulses of the Id and the Superego's controls.

SUPEREGO – is the moral branch of the personality. It represents the ideal rather than the real and strives for perfection. It represents the traditional values and the ideals of society. It rewards through feelings of pride and self-love; it punishes through feelings of guilt and inferiority. Freud believed that successfully resolving the Oedipus complex gives rise to the superego.

B. Psychic energy and early experiences **determine** personality development (a deterministic philosophy).

C. Current behavior is impacted by unconscious motives and conflicts.

D. Sexual and aggressive impulses are foundational to actions and to personality development.

- **Oedipus Complex** – son's attraction for his mother
- **Electra Complex** – daughter's attraction for her father

E. Early experiences are critical; later personality development is successful only if early childhood conflicts are resolved, rather than repressed.

F. Counseling includes **four primary phases** which all pertain to transference:

1. **opening**
2. **developing**
3. **working through**
4. **resolving**

G. **ANXIETY** – is the state of tension that motivates us to do something. Its function is to warn of impending danger and to signal to the ego to take action else the ego will be overthrown. Three kinds of anxiety are the following:

1. **Real**
2. **Neurotic**
3. **Moral**

H. Anxiety is controlled through the development of **ego defense mechanisms**.

I. **Catharsis/Abreaction** – purging of emotions and feelings by giving them expression.

J. **Parapraxis** – an action in which one's conscious intention is not fully carried out, as in the mislaying of objects, slips of the tongue and pen, etc. (Freudian slips).

K. **Countertransference** – The counselor substitutes the client for the original object of the counselor's own repressed impulses (counselor's being extremely angry with or sexually attracted to a client).

X. Techniques Specific to the Psychoanalytic Model

- A. Psychoanalytic techniques are intended to make the client aware of unconscious conflicts. Insight then results allowing the ego to assimilate new material.
- B. Principal techniques include:
 - 1. **Interpretation** – helping client gain **insight** into both past and present events
 - 2. **Dream Analysis** – interpreting the **manifest** (obvious) and **latent** (hidden) meanings of dreams
 - 3. **Free Association** – verbalizing whatever comes to mind, even if trivial
 - 4. **Analysis of Resistance** – helping client understand the basis for hesitation or stopping progress in therapy
 - 5. **Analysis of Transference** – the client transfers or attributes issues from prior significant authority figures onto the counselor
- C. Case histories are developed from questioning. Testing and diagnosis are often employed.

XI. Criticisms of the Psychoanalytic Model

- The functions of the id, ego, and superego cannot be empirically tested.
- Not suitable in the common counseling setting.
- Not suitable for many minority, ethnic, or cultural groups.
- Not suitable for solving specific problems of lower socioeconomic individuals.
- Social, cultural, and interpersonal influences are largely ignored.
- Regressive and reconstructive therapy requires ego strength that is not always present.
- The training time for counselors is lengthy, often considered impractical.
- Classic psychoanalysis positions the client on a couch performing free association with an unseen analyst. This expensive process requires several sessions a week for several years.

XII. Additional Information Related to the Psychoanalytic Model

- Freud's psychoanalytical model was the first counseling model. The terms and concepts of his personality theory are foundational to this counseling model and can be found in the chapter on Normal Human Growth and Development in this Study Manual.
- Freud authored *The Interpretation of Dreams*, often called "the Bible of Psychoanalysis," in 1900.
- Freud studied with Josef Breuer, who taught him the benefits of the talking cure or catharsis. **Anna O.**, thought to be the first psychoanalytic patient, was diagnosed with hysteria (symptomology with no organic basis). During hypnosis she could recall painful events she could not talk about otherwise. Talking about these events later brought her relief. While Freud later moved away from hypnosis, these experiences led him to his foundational premise that techniques producing catharsis are therapeutic.
- Freud's reason for moving away from hypnosis was apparently at least two-fold:
 1. He was quoted as saying that he was not very good at it
 2. He believed that symptom substitution (dealing with only the symptom and not the underlying cause could result in the emergence of an additional symptom) could occur
- Freud used his constructs of the Oedipal complex and castration anxiety to explain the fear of a five year-old boy named **Little Hans**. Little Hans was afraid to go into the streets where he thought a horse might bite him.
- Freud analyzed the diary of Daniel **Schreber**, a mental patient for 9 years, and came to the conclusion that Schreber's paranoia grew out of unconscious homosexual feelings.
- **EGO-DEFENSE MECHANISMS** – assist in coping with anxiety and defend the ego by either denying or distorting reality. They operate on an unconscious level. (See next page)

EGO DEFENSE MECHANISMS

1. **Displacement** – means displacing or directing emotion onto a person/object other than the one that originally aroused the emotion.
Example: A meek employee, who is continually ridiculed by her boss, builds up tremendous resentment but verbally attacks family members instead of her boss, who might fire her.
2. **Rationalization** – is justifying behavior to oneself and to others with well thought-out and socially acceptable but fictitious reasons for certain behaviors. This is not just lying; it's a matter of habit and intensity.
Example: A high school student explains away her failing of an algebra exam by saying, "I really don't see why I have to take this course. I don't need it to graduate and that teacher just sits there and doesn't explain anything."
3. **Compensation** – means attempting to overcome the anxiety associated with a feeling of inferiority in one area by concentrating on another where the person can excel. This may be healthy and constructive; it may be avoidance.
Example: A woman who cannot bear children becoming overly attached to pets.
4. **Projection** – entails attributing to another person feelings and ideas that are unacceptable so the other person seems to have these feelings and ideas.
Example: Feeling like a coward in handling a situation but blaming the outcome on the cowardice of the other person.
5. **Reaction Formation** – involves exaggerating and openly displaying a trait that is the opposite of the tendencies that we do not want to recognize (traits that have been repressed).
Example: People who are zealots about smut but really have hidden desires.
6. **Denial** – means failing or refusing to acknowledge or to recognize and deal with reality because of strong inner needs.
Example: Ignoring the symptoms of a heart attack; wearing copper bracelets.
7. **Repression** – is an unconscious process of blocking urges, forbidden or dangerous desires, or traumatic experiences from consciousness. The most basic defense mechanism according to Freud. (Suppression is a conscious process.)
Example: A police officer who witnesses the violent death of a fellow officer may press the incident out of consciousness because it symbolizes his own mortality.
8. **Identification** – is the attempt to overcome feelings of inferiority by taking on the characteristics of someone important to oneself.
Example: A student who takes on characteristics/attributes of his/her mother, father, favorite teacher, or coach.

9. **Substitution** – involves achieving alternate goals and gratifications in order to mask feelings of frustration and anxiety.
Example: Young girls who miss their father shacking up with older men.
10. **Fantasy** – involves retreating in one’s mind to a comfortable (maybe ideal) setting. While one of the most useful defense mechanisms, it can become addictive and substitute for honest effort.
11. **Regression** – consists of reverting to a pattern of feeling, thinking or behavior appropriate to an earlier stage of development.
Example: A competent and capable adult acting very childish when sick in an attempt to have those around them provide greater care.
12. **Sublimation** – is the redirecting of unacceptable impulses into socially and culturally acceptable channels.
Example: Ones need for approval leading to an interest in theatre productions.
13. **Introjection** – is the taking in, absorbing or incorporating into oneself the standards and values of another person.
Example: The abused child who becomes an abusive parent.
14. **Undoing** – occurs when a person acts inappropriately thus producing anxiety; then the person acts in an opposite way so as to reverse or negate the original behavior thus extinguishing the original anxiety.
Example: A child yells at the dinner table and then offers to help with the dishes.
15. **Emotional Insulation** – is protecting oneself from hurt by withdrawing into passivity.
Example: “Looking for a new job will bring rejection so I’ll just go with the flow and see what happens.”
16. **Isolation** – is separating the emotion from an experience so as to deal dispassionately with an otherwise emotionally overwhelming topic.
Example: Making funeral arrangements instead of grieving.

ADLERIAN THERAPY OR INDIVIDUAL PSYCHOLOGY

I. Major Figures

Alfred Adler

Rudolf Dreikurs was a student of Adler who eventually brought the child guidance center concept to the U.S. He initiated group therapy into private practice.

Donald Dinkmeyer, Sr. is a current Adlerian proponent.

II. Overview of the Adlerian Model

- Alfred Adler originally collaborated with Freud but broke away in 1911 as he became convinced that external, social forces play as important a role, if not a more important role, in personality development. As such, Adlerian therapy was one of the first humanistic, unified, holistic approaches that recognized social and psychological influences.
- Humans, in Adler's view, are goal oriented and are motivated by social urges and a desire to overcome inferiority. Successful lifestyle is in terms of superiority, i.e., self-actualization. He established the first community-outreach program: child guidance centers.
- Each person has a positive capacity to live cooperatively socially and can interpret, influence, and create events to make this happen.
- The conscious, rather than the unconscious mind, is the foundation of personality development.

III. Goals of Adlerian Treatment

- To help the client develop a healthy self-esteem and lifestyle through reeducation and restructuring.
- To question and challenge clients' perceptions of self and life beliefs and goals (target faulty logic, misdirected goals).
- To help the client cultivate healthy social interests.
- To provide encouragement toward meaningful goals.

IV. Role of the Adlerian Counselor

- The counselor is a cooperative partner with the client in establishing mutual respect and trust and in mutually outlining goals.
- Joint responsibility is established through a therapeutic contract.
- As a diagnostician, teacher, and model, the counselor focuses on identifying and bringing to awareness faulty assumptions and goals and then educating the client on changing resulting behavior.

V. Normal Development

- Our life struggle is between achieving the goal of superiority versus the social realities that make us feel inferior to the task.
- Our life tasks are social, occupational, sexual, spiritual, and self-relationship directed.
- As an individual takes personal responsibility for his or her behavior, a positive self-esteem and purposeful, goal-directed behavior results.

VI. Development of Behavioral Disorders

- Discouragement is at the root of psychopathology.
- Basic mistakes are faulty perceptions, values, or goals that keep us from achieving superiority (Mosak, 1998):
 1. Overgeneralization
 2. Misperceptions of life and life's demands
 3. Impossible or false goals of security
 4. Denial or minimization of one's worth
 5. Faulty values
- Children who are discouraged will endeavor to achieve the desired social interest through one of four goal directed behaviors:
 1. Prove their power
 2. Display deficiencies
 3. Get attention
 4. Get revenge
- Adler authored *Organ Inferiority* in 1907 to articulate his assumption that the wish for power was a crucial motivating force (thus his term inferiority complex). The individual attempts to compensate for inferiority.
- This concept evolved into the “striving for superiority” or drive for perfection (not to be confused with a desire to dominate others or a superiority complex).
- **Over-compensation** is the reacting to a real or imagined physical or psychological defect with an exaggerated drive to compensate for it.

VII. Applications of the Adlerian Model

- This growth model is well suited to preventive care and is able to deal with the broad range of conditions that interfere with growth.
- Some specific target clients would include:
 1. Individuals of all ages
 2. Child guidance
 3. Parent-child counseling
 4. Family therapy
 5. Couples therapy
 6. Group counseling
 7. Rehabilitation and/or correctional counseling
 8. Substance abuse counseling
 9. Brief, solutions-oriented counseling

VIII. Suitability of the Adlerian Model in Multicultural Settings

- Suitable for cultures that value:
 1. Family relationships but believe what happens “stays in the family”
 2. The pursuit of meaning and value in life
 3. Goal setting and goal attainment
 4. Cultural/environmental factors
 5. Social belonging and connectedness
- Not suitable for:
 1. Cultures which disapprove of revealing family background information
 2. Clients preferring an authoritarian, tell-me-what-to-do counselor

IX. Key Adlerian Concepts and Terms

- Understanding a person is accomplished through viewing his or her own subjective perception of self.
- A person is viewed as having a unified, integrated personality.
- Life goals, rather than biological urges, direct behavior.
- Individuals are motivated by seeking a **feeling of belonging or social connectedness**; life should have meaning and significance.
- Individuals **strive for perfection, superiority**, or success; in other words, they strive to overcome areas of personal inferiority.
- Individuals will develop a unique lifestyle (subjective convictions, world view, and self-view) at an early age that will stay relatively constant through life (Corsini, 1984).
- The family constellation is of utmost importance. Adler’s child-guidance clinics allowed him to directly observe the behavior of children. One of his conclusions was that sibling interactions may have more impact on development than parent-child interactions.
- Sometimes, Adlerian counselors use these terms or phrases as well:
 1. mistaken goals
 2. insight
 3. self-defeating behaviors
 4. options
 5. action-oriented plan
 6. family constellation (includes birth order)
 7. challenge/confrontation
 8. open-ended interpretation
 9. re-orientation
 10. over-compensation

X. Techniques Specific to the Adlerian Model

- Specific techniques are secondary to the acknowledgement of the client's subjective experiences.

Techniques are chosen from an eclectic framework and may include:

- **Collecting life-history information** – early recollections, family constellation, personal values and priorities
- **Interpretation** – primarily meant to bring awareness of unconscious processes to the client. Secondary benefits will be realized as well: The counselor will appear genuine. Nonverbal behaviors will be recognized. Childhood issues that are currently affecting behavior and feelings will be revealed.
- **Confrontation** – challenging the client's logic and inconsistent behavior
- **Encouragement** – supporting the client by asserting that the client can take personal responsibility and change behavior
- **Asking “the Question”** – How would life be different if this problem were solved?
- **“Spitting in the client's soup”** – the counselor states the real purpose of a behavior; the client may then continue the behavior but only with the awareness of the true motivation
- **Task setting** – setting short-term goals that progress toward long-term goal attainment
- **“Catching oneself”** – the client learns to recognize self-destructive behavior and to stop it
- **Acting “as if”** – behaving as if the problem is solved or the goal is achieved
- **Paradox** – acting in an exaggerated way regarding a feared behavior or event; Adler was one of the first to rely on paradox as a technique

XI. Criticisms of the Adlerian Model

- Conditions, perceptions, personality growth, etc. cannot be empirically tested.
- The basic Adlerian concepts have not been scientifically scrutinized and validated.
- Common sense plays a major role.
- Complex human problems can be seemingly oversimplified.

XII. Additional Information Related to the Adlerian Model

- Adlerian and other psychodynamic counseling models use face-to-face methods with the counselor and client sitting across from each other.
- Fewer sessions are required compared with classical psychoanalytical counseling.

OTHER NEO-FREUDIANS OR PSYCHODYNAMIC ANALYSTS

Like Adler, these theorists initially agreed with Freud but later broke away from him. For ease of study, we have kept them labeled as Neo-Freudians and have summarized the areas in which these theorists **differed from Freud**. Each of these theorists would agree with Freud's foundational tenets and principles. They primarily showed their differences from Freud via their concepts and terminology.

CARL JUNG — ANALYTICAL PSYCHOLOGY

Jung DIFFERED FROM Freud in the following area.

Key Concepts and Terminology (Roman Numeral IX under Freud)

- Jung broadened Freud's concept of the unconscious and said it could be developed and tapped.
- He taught the realizing of self (living for purpose and meaning) through dealing with the levels of the unconscious, especially with dream analysis.
- Jung differentiated between the ways men and women process experiences (Jung, 1961).
- Personal or individual unconscious – What was once conscious but is now repressed experiences.
- Collective unconscious – Made up of archetypes (Buried inherited memories from the ancestral past).
- Anima and animus – Humans have both feminine and masculine characteristics. Jung believed that society encourages men to deny their feminine side and women to deny their masculine side.
- Men operate on logic or the logos principle; women operate on intuition or the eros principle.
- Jung used **mandalas**, concentric circular designs, to represent the relationship between himself, his clients, and his dreams. The mandala also symbolized self-unification.
- Persona – Public self
- Shadow – Repressed self
- Self
- Extroversion and introversion – **Polarities** within humans.
 - a. **Introversion** is a turning in towards oneself as the main source of pleasure.
 - b. **Extroversion** seeks pleasure and satisfaction in others.
- Personality types:
 - a. Thinking
 - b. Feeling
 - c. Sensing
 - d. Intuitive
- The bipolar personality types used in the **Myers-Briggs Type Indicator** are associated with the work of Jung.

ERICH FROMM

Fromm DIFFERED FROM Freud in the following area.

Key Concepts and Terminology (Roman Numeral IX under Freud)

- Humans are influenced by social and cultural forces but shape their own nature.
- Humans by nature experience isolation and alienation.
- Options for relief are learning how to love or finding security by conforming one's will to authority (Rosenbaum & Seligman, 1989).
- Five basic needs:
 1. Relatedness
 2. Transcendence
 3. Rootedness (to world, nature, and others)
 4. Identity
 5. Frame of orientation (to make sense out of the world)
- Character Types:
 1. Receptive
 2. Exploitive
 3. Hoarding
 4. Marketing
 5. Productive

OTTO RANK

Rank DIFFERED FROM Freud in the following area.

Key Concepts and Terminology (Roman Numeral IX under Freud)

- The person's goal is to return to the security experienced in the womb.
- The person struggles for individuality (Hunt, 1993).
- Separation anxiety
- Character types
 1. Average
 2. Neurotic
 3. Creative

ERIK ERIKSON

Erikson DIFFERED FROM Freud in the following area.

Key Concepts and Terminology (Roman Numeral IX under Freud)

- Psychosexual and psychosocial growth occurs simultaneously.
- Erikson conceived ego identity as the polarity of what "one feels one is and what others take one to be."
- There is continuity in development from birth through old age (Santrock & Yussen, 1987).

Developmental Stage	Psycho-social Crisis
1. Early infancy (Birth - 1 year)	Basic trust vs. mistrust
2. Later infancy (1 - 2 years)	Autonomy vs. shame & doubt
3. Early childhood (3 - 5 years)	Initiative vs. guilt
4. Middle childhood (6 - 11 years)	Industry vs. inferiority
5. Adolescence (12 - 20 years)	Identity vs. role confusion
6. Early adulthood (20 - 35 years)	Intimacy vs. isolation Sharing one's life with others vs. I'm the only one I can depend on
7. Middle adulthood (35 - 65 years)	Generativity vs. stagnation The productive ability to create a career, family, leisure time, etc. vs. self-absorption
8. Late adulthood (65+ years)	Integrity vs. despair Life has been worthwhile vs. life's precious opportunities have been wasted.

HARRY STACK SULLIVAN

Sullivan DIFFERED FROM Freud in the following area.

Key Concepts and Terminology (Roman Numeral IX under Freud)

- Personality manifests itself through relationships beginning with the infant's relationship with its primary caregiver.
- Personality is malleable (influenced by relationships).
- The emphasis is on a power motive as a means to overcoming a sense of helplessness.
- The self-system is the power system formed as a reaction against the anxiety produced in relationships (Rosenbaum & Seligman, 1989).
- Modes of experience involved in ego formation:
 1. **Protaxic** – Infancy; the infant has no concept of time and place.
 2. **Parataxic** – Early childhood; the child accepts what is without questioning or evaluating and reacts on an unrealistic basis.
 3. **Syntaxic** – Later childhood; the child is able to evaluate his/her own thoughts and feelings against those of others and learns about relationship patterns in society.
- Four stage interview (learns about relationships in society):
 1. Inception
 2. Reconnaissance
 3. Detailed inquiry
 4. Termination

KAREN HORNEY

Horney DIFFERED FROM Freud in the following area.

Key Concepts and Terminology (Roman Numeral IX under Freud)

- Horney purported an inborn potential for self-realization.
- Character develops out of childhood experiences and basic security needs (Horney, 1967).
- Basic anxiety – the child's feelings of being isolated and helpless in a potentially hostile world. Anything that disturbs basic security yields basic anxiety.
- Ten neurotic needs:
 1. affection/approval
 2. dominate partner
 3. restricting one's life
 4. power
 5. exploitation of others
 6. prestige
 7. independence
 8. personal achievement
 9. personal admiration
 10. protection
- Character types:
 1. Compliant
 2. Aggressive
 3. Detached

EXISTENTIAL - HUMANISTIC THERAPY

I. Major Figures

Abraham Maslow

Rollo May

Victor Frankl

II. Overview of the Existential–Humanistic Model

- Existentialism has been so identified with humanism that the terms are often used together, many times as a hyphenated term. Both existentialism and humanism emphasize existence, the present, and the meaning of existence. The literature in the field does not consistently assign theorists to either philosophical side but does point out that the need to self-actualize, to exhibit automatic positive growth, is a humanistic quality. Existentialism, on the other hand, recognizes a freedom to both grow or decay.
- Kierkegaard, a nineteenth-century Danish theologian and philosopher, asserted that each person carves his or her own destiny, and his or her essence (inner being) is the product of his or her actions.
- Seventy years later, Heidegger and Sartre expounded on existential themes by arguing that people are never isolated from or independent of the objects around them. People are engaged with the objects around them via their perceptions, moods, and feelings. Such subjectivity influences the existential nature of people's existence.
- Concepts such as Maslow's self-actualized person (and the framework of the hierarchy of needs) set the existential humanistic philosophies apart from both classical psychology and the behaviorists who believe that human thought and behavior are predictable consequences of identifiable training processes.
- Existential Humanistic psychology is called "third force psychology" because it was a reaction to the two initial forces at the time – psychoanalysis and behaviorism.

III. Goals of Existential–Humanistic Treatment

- Guide clients to greater self-awareness through exploring possibilities and by identifying factors that block awareness and freedom.
- Increase the client's view of his or her freedom to make choices and create meaning.
- Validate the importance of responsibility, freedom, awareness, and potential.

IV. Role of the Existential–Humanistic Counselor

- The existential counselor is fully committed to an authentic, deeply personal, shared relationship with the client.
- The counselor must accurately understand the client’s being-in-the-world.
- The counselor models authenticity, realizing personal potential and decision making within the context of self-awareness.
- The authentic encounter can change both the therapist and the client.

V. Normal Development

- Each individual is unique and therefore has a unique path of personality development.
- One’s sense of self begins and develops from infancy.

VI. Development of Behavioral Disorders

- Psychopathology results from making negligent choices or failing to emphasize and reach for one’s higher potential.
- Guilt results from not acting responsibly.
- Anxiety results from an inconsistent relationship between one’s perception of meaning and purpose in life with one’s awareness of the reality of death.

VII. Applications of the Existential–Humanistic Model

- Existential/humanistic therapies are useful in these settings:
 1. Individual
 2. Group
 3. Couples
 4. Family
 5. Crisis intervention
 6. Community mental health
- Existential/humanistic therapies are useful for these types of issues/problems:
 1. Increased personal awareness and self enhancement
 2. Transitions in life or developmental junctures
 3. Guilt or anxiety
 4. Making decisions or choices
 5. Balancing freedom and responsibility
 6. Determining values
 7. Finding meaning or making sense of life

VIII. Suitability of the Existential Model in Multicultural Settings

- Suitable for:
 1. Counseling where the cultural background is an important factor.
 2. Exploring options for change within the confines of the client's culture.
 3. Imparting empowerment in an other-wise oppressive cultural context.
- Not suitable for:
 1. Clients preferring directives regarding surviving life rather than the meaning of life.
 2. Clients with cultural values that include yielding to authority, regard for tradition, collectivism, and interdependence as opposed to a striving for autonomy and one's maximum potential.
 3. Clients preferring well-defined, specific techniques of treatment.

IX. Key Existential–Humanistic Concepts and Terminology

- One shapes one's own destiny. One is free to choose and is responsible for the consequences of his/her choices. Existence precedes essence; what one does determines who he/she is.
- Consciousness creates itself over and over again.
- One's existence defines one's life. One's existence is never completely separate from the existence of others and the world, and the existence of the world is never completely separate from one's existence.
- One's life is always lived with a view toward death. One's authenticity derives from his/her ability to be aware of this. Death is not seen as a negative or an evil concept but rather as something that gives meaning and lends importance to the process of life.
- Perception is more valid when subjective preconceptions are bracketed out.
- **Being-in-the-world** refers to the unique way the client experiences self and the world and gives direction to life. This being-in-the-world is accepted as real, meaningful, and legitimate.

Being-in-the-world is spoken of as having three different patterns:

1. **Umwelt** – refers to behaviors grounded in the **physical**: human biology (sleeping, eating, excreting, copulating) and aiming at biological survival and satisfaction.
 2. **Mitwelt** – refers to interpersonal **relationships** in which there is sharing or encounter, which seeks to prevent or to alleviate feelings of loneliness or aloneness and to enrich life.
 3. **Eigenwelt** – refers to behaviors of self-awareness, self-evaluation, and **self-identity**, which attempt to make one's life meaningful.
- **Phenomenology** – the study of perceptual experience in its purely subjective aspect. The basis of psychology should be the scientific study of immediate experience. The objective reality of events is not denied; rather, the emphasis is on how the events are perceived and experienced.
 - **Ontology** – This philosophy seeks to explain the nature of being or reality or ultimate substance (stands opposed to Phenomenology).

- **Abraham Maslow** (1962) sees man's highest need as a need for "self-actualization" – the need to realize one's innate capacities and talents.
- **Rollo May** (Hunt, 1993) is credited with developing existential psychotherapy in the U.S. He emphasized each person's individuality and the need for the counselor to separate himself or herself from preconceived diagnostic categories in attempting to understand and treat the patient.
- **Victor Frankl** (Hunt, 1993) is the founder of Logotherapy which can be defined as meaning-centered psychotherapy.

Frankl believed that there are three ways to discover meaning in one's life:

- By **doing a deed** (accomplishing or achieving something)
- By **experiencing a value** (love, beauty, art, etc.)
- By **suffering** (reconciling oneself to fate)

Some key words of **Frankl's**:

1. **Paradoxical intention** – is evidenced by the neurotic deliberately attempting to bring about a feared event and recognizing the unrealistic nature of his anxiety when the feared consequence does not happen.
2. **Dereflection** – is the process of changing the center of attention from oneself to an external focus.
3. **Existential Frustration** – is the discomfort and frustration coming from the inability to find meaning in one's life.
4. **Existential Vacuum** – is having the feeling of ultimate and total meaninglessness in one's life. It is the inner emptiness that the client feels with neurosis.
5. **Noology** – Frankl's term for the study of that which is uniquely human. He felt that theology encompassed noology and that noology encompassed psychology.
6. **Noogenic neurosis** – A Logotherapy term referring to the frustration of the will to meaning. It's the state or condition of the will being perpetually frustrated in its attempt to find meaning in the world.
7. Frankl wrote *Man's Search for Meaning*.

X. Techniques Specific to the Existential–Humanistic Model

- The authentic, mutually personal counselor-client relationship is the main technique used.
- Confrontation is used to spur clients toward self-responsibility.
- Techniques from other approaches are chosen as they are deemed useful in helping the client toward self-awareness.
- Action is preceded by self-awareness.

XI. Criticisms of the Existential–Humanistic Model

- No systematic delineation of treatment principles and practices exists; therefore, the general framework is often perceived as ill-defined and vague.
- Traditional diagnostic and assessment procedures are rejected.
- Non-verbal and lower functioning individuals do not possess the skills to interact in the necessary exploratory process.
- Clients in severe distress will need more direction than is available through existential treatment.

XII. Additional Information Related to the Existential–Humanistic Model

This model is based on the philosophy of existentialism originated by **Soren Kierkegaard** (asserted the priority of individuals over systems) and later **Martin Heidegger** (included elements of phenomenology – the assertion that the basis of psychology should be the scientific study of immediate experience) and **Jean-Paul Sartre** (analyses through drama and literature). Other existentialist names include **Irvin Yalom** (noted for his work in group therapy), **Ludwig Binswanger** and **Medard Boss** (both psychoanalytically trained but influenced by Heidegger), **Karl Jaspers** (also psychoanalytically trained but integrated the concern for personal values and concrete experience), and **Martin Buber** (coined the term “I – Thou” meaning a horizontal equal relationship with others).

Roger’s Person-Centered therapy model and Perls’ Gestalt therapy model are both considered as existential-humanistic models because of their emphasis on the present and on choice.

PERSON-CENTERED THERAPY (CLIENT-CENTERED)

I. Major Figure

Carl Rogers

II. Overview of the Person-Centered Model

- Client-centered therapy is America's first distinctively indigenous school of therapy. It was conceived and nurtured by Carl R. Rogers and is sometimes referred to as Rogerian therapy.
- While the histories of many other schools of therapy are strewn with schisms and rebellion against the original concepts, client-centered therapy is nonprescriptive and responsive enough to allow the expression of individual techniques and styles within the accepted framework (Belkin, 1987).
- The basic principle of "an open and accepting attitude" must be adhered to.
- The therapy is flexible because the client directs the movement of his or her own treatment.
- Note the different names all referring to the same basic theory:
 - Initially called Nondirective Counseling
 - Changed to Client-Centered
 - Updated to Person-Centered
 - Sometimes known as Self Theory

III. Goals of Person-Centered Treatment

- No predetermined goals are outlined other than the understood purpose of increasing self-awareness and increasing the trust in one's own actualizing process.
- This self-awareness includes the clients exploring their roadblocks to growth and recognizing parts of self that were previously denied or distorted.
- The real relationship with the counselor becomes a springboard to transfer learning to other relationships.

IV. Role of the Person-Centered Counselor

- The counselor's primary task is to provide what Rogers called a therapeutic atmosphere which stems from the counselor core conditions. Just the presence of these core conditions or attitudes will create change in the client toward self-actualization. This environment provides the safety for a client to explore any aspect of self.
- Three core conditions of the therapist:
 1. **Congruence (genuineness)** – The counselor is aware of and accurately expresses his or her own feelings; is authentic and genuine.
 2. **Unconditional positive regard** – The counselor accepts the client without judgment.
 3. **Accurate empathy** – The counselor truly understands the thoughts and feelings of the client.

Of these, Rogers considered **congruence the most important**.

- This non-directive approach emphasizes **reflection of emotional content** which occurs when a client's verbalizations are restated in such a way as to bring awareness of emotions to the client.
- So, if one is a Rogerian counselor, has empathy, feels what his/her client is feeling, and sees the situation as the client sees it, he/she will be **non-judgmental**.
- The therapist is not viewed as the traditional "expert."
- Diagnosing, probing, and interpretation are laid aside.

V. Normal Development

- Men and women have an inborn tendency toward self-actualization, toward growth and full functioning.
- Basic striving is to actualize, maintain, and enhance.

VI. Development of Behavioral Disorders

- Pathology results when the inborn tendency toward self-actualization is hampered. Needing love and belonging (similar to Maslow's hierarchy) can impede growth. The frustration of basic impulses can impede growth.
- A lack of self-knowledge hampers an individual's ability to resolve conflicts.
- Conflicts are the discrepancy between self-perception and experienced reality.
- The greater the incongruence between the real self and the ideal self, the greater the maladjustment.

VII. Applications of the Person-Centered Model

- The person-centered approach is widely applicable with:
 - Individuals
 - Groups
 - Crisis intervention
 - Community mental health
 - Couples
 - Family and parent/child
 - Management (and Administration) training
 - Human relations training
 - Culturally diverse groups

VIII. Suitability of the Person-Centered Model in Multicultural Settings

- Suitable for:
 1. Breaking cultural barriers.
 2. Encouraging dialogue among culturally diverse populations.
 3. Engaging in sessions in which valuing cultural pluralism is needed.
 4. Responding nonjudgmentally to clients' differences and values.
 5. Clients willing to decide the topics to be explored.
- Not suitable for:
 1. Cultures with other core values.
 2. Clients seeking immediate help and direct answers from an expert.
 3. Culture groups expecting more counselor activity.

IX. Key Person-Centered Concepts and Terminology

- This positive view of humans asserts that people have a natural tendency toward striving to reach one's full potential.
- Mental health results from a congruence of the ideal self and the real self as the client realizes his or her potential with increased awareness, spontaneity, aliveness, openness, self-direction, and self-trust.
- Humans have the potential to become aware of problems and to resolve them.
- The client has the capacity for self-direction and the willingness to be a process rather than a finished work.
- The focus is phenomenological – on the present experience and how it is being experienced and expressed.

X. Techniques Specific to the Person-Centered Model

- The counselor's attitude is of primary importance and colors any specific techniques used.
- Person-centered counselors would use any of the following:
 1. Reflection
 2. Active listening
 3. Confrontation
 4. Open-ended questions
 5. Summarization
 6. Clarification
 7. Support
 8. Reassurance
- No diagnosis or interpretations; only minimal probing.
- No making judgments, giving advice, suggesting solutions, or moralizing.
- A strict Rogerian would generally not tell a client "how to think," nor would a strict Rogerian give a client detailed methods to achieve behavioral change.

XI. Criticisms of the Person-Centered Model

- Many clients, especially those in crisis, feel a need for direction and structure from the counselor.
- The success of the treatment depends on the counselor's attitude; the counselor must be vigilant to remain an active participant and not let responses slip to just reflection.
- Nonverbal clients such as young children or the disadvantaged cannot be self-expressive as this approach requires.
- No spiritual or environmental influences are considered in the theory.
- No problem-solving approach is included in the theory.
- Current experience would indicate that an action phase is necessary in the counseling process. In other words, some directiveness is required after the relationship between the counselor and the client is established, or the therapy goes in the proverbial circle.
- While Rogers encouraged caring confrontation, counselors often fail to employ the technique.
- While Rogerians tout empirical testing of the approach, critics point out that some of the studies lacked a control group, did not employ appropriate statistical techniques, based conclusions on self-reports of the client, or did not take the placebo effect into account.

XII. Additional Information Related to the Person-Centered Model

Basic encounter groups and personal growth groups were initiated, developed, and promoted by Rogers in the 1960s and 1970s. A weekend workshop format was utilized. The lines between “therapy” and “growth” blurred as the therapists became increasingly involved in the interactive therapy.

GESTALT THERAPY

I. Major Figure

Fritz Perls

II. Overview of the Gestalt Model

- This experiential approach is antideterministic in that personal choice and responsibility are emphasized.
- Gestalt does not translate exactly into English but roughly means a form, figure, or configuration unified as a whole. It can also mean essence or manner. The primary focus is on the unified whole which is different from the sum of its parts.
- The term gestalt (Perls, 1969) was borrowed from Max Wertheimer and his psychology of studying perceptual phenomena (e.g., figure/ground relationships). The three most common gestalt concepts are:
 1. **Insight Learning** as discovered by Wolfgang Kohler
 2. **Zeigarnik Effect** as proposed by Bluma Zeigarnik; unfinished tasks are more readily recalled than finished tasks
 3. **Phi-phenomenon** as proposed by Wertheimer wherein the illusion of movement can be achieved by two or more stimuli which are not moving (neon sign with a moving arrow)

III. Goals of Gestalt Treatment

- The emphasis is to help the client live a fuller life in order to be fully integrated.
- Since awareness is believed to be curative, the “here and now” should be fully experienced including confronting unfinished business and other forms of resistance and blocked energy.
- The client is taught to be self-supporting, to take responsibility for feelings, thoughts, and actions.
- Insight is prized.

IV. Role of the Gestalt Counselor

- To help the client explore his or her needs in order to discern life patterns, to focus on using energy to adapt positively, and to grow.

V. Normal Development

- Humans have an innate capacity to function and to live successfully.
- People can become self-regulating and achieve a sense of unity and integration.

VI. Development of Behavioral Disorders

- Overemphasizing intellectual experience to the neglect of the emotions and senses leads to maladaptive behavior.
- Introjection and reduced awareness result from being taught to devalue and to distrust oneself.
- Perls outlined **five layers of neuroses** (likened to the layers of an onion) (Corey, 2000):
 1. **Phony layer** – not authentic, playing games, playing roles, following stereotypes.
 2. **Phobic layer** – emotional pain resulting from denying parts of self is avoided; self-acceptance is resisted; fear of rejection will be experienced if one is who he/she really is.
 3. **Impasse layer** – feeling stuck and not trusting inner resources; sense of deadness.
 4. **Implosive layer** – the deadness is fully experienced, defenses are exposed, and contact with the genuine self is begun.
 5. **Explosive layer** – pretenses and phony roles are abandoned; the energy previously required to maintain the pretenses is not free to be redirected.

VII. Applications of the Gestalt Model

Any situation which is helped by doing and experiencing instead of just talking about feelings:

1. Individual
2. Group
3. Couples
4. Family
5. Children's behavior issues
6. Awareness training (for mental health professionals and others)
7. Crisis intervention
8. Many psychosomatic disorders
9. Teaching and learning

VIII. Suitability of the Gestalt Model in Multicultural Counseling

- Suitable for:
 1. Cultures which promote nonverbal expression
 2. Those willing to recognize the relationship between bodily expression and internal conflicts
 3. Freeing up expression when the culture does promote free expression
 4. Overcoming language barriers
- Not suitable for:
 1. Those not willing to accept the connection between “being aware of present experiencing” and solving problems.
 2. Those who have been emotionally reserved due to cultural conditioning.

IX. Key Gestalt Concepts and Terminology

- With an emphasis on the interaction of **thinking, feeling, and behaving** to produce wholeness, gestalt therapists consider these concepts to be significant:
 1. Awareness – focusing on the present moment
 2. Holism – how the parts of a person fit together
 3. Avoidance and unfinished business – unexpressed, avoided feelings
 4. Process of figure formation – how an aspect of the environment takes a focal role
 5. Placement, blocking, and usage of energy
 6. Contact with the environment without losing one’s sense of individuality
- Ego defense mechanisms are called **channels of resistance** and prevent effective contact (interacting with others and with nature without losing one’s sense of individuality):
 1. **Introjection** – Accepting another’s beliefs or standards without analyzing and restructuring them to make them congruent to oneself.
 2. **Projection** – Disowning and putting on other people’s personality characteristics of self that are inconsistent with one’s self-image; the reverse of introjection.
 3. **Retroflection** – Turning back to oneself what he/she would like to do to someone else or doing to oneself what he/she would like someone else to do to him/her.
 4. **Confluence** – Blurring the line between self and the environment; blending in to the point that there is no clear line between outer reality and inner experience.
 5. **Deflection** – Using humor, abstract generalizations, and questions rather than statements, etc. as distractions so a sustained sense of contact is avoided (Corey, 2001).

X. Techniques Specific to the Gestalt Model

A broad range of exercises and experiments is employed to intensify experiencing and to integrate conflicting feelings. These exercises and experiments grow out of the I/Thou relationship between the client and the counselor and are not viewed by the Gestaltist as merely mechanical techniques:

1. **Confrontation** – calls attention to discrepancies and incongruencies
2. **The “Empty Chair”** (also called games of dialogue) – addressing a part of the personality as if it were sitting there in a chair; underdog (weak, powerless, passive, full of excuses), top dog (authoritarian shoulds and oughts) or masculine versus feminine traits.
3. **Reliving** and thereby experiencing unfinished business in the here and now with its attending resentment and guilt.
4. **Exaggeration** – overdramatizing gestures and movements to gain insight; similar to Frankl’s paradox.
5. **“Making the Rounds”** – a group exercise in which the client repeats the same words to each member adding a personalized phrase.
6. **Role-playing or psychodrama** (introduced by Moreno).
7. **Stay with the feeling** – do not avoid the feeling.
8. **Rehearsal exercise** – sharing internalized rehearsals of situations.
9. **Dream work** – dreams are recounted as if they are in the here and now; every facet of the dream is considered a projection of self.
10. **“I statements”** – instructing the client to take personal responsibility for a thought or feeling by making an “I feel.....” or “I take responsibility for.....” statements.
11. **“How” and “what” questions** instead of “why.”
12. **Interpretation by the client**, not the counselor.
13. No formal diagnosis or testing is required.
14. “Frustration is therapeutic.”

XI. Criticisms of the Gestalt Model

- Considered by some as anti-intellectual: Perls said, "Lose your mind and come to your senses."
- A certain degree of imagination is required to profit from gestalt experiments.
- Just bringing intense emotional expression to the surface can be damaging if further exploration and cognitive work are not done to produce a sense of integration.

XII. Additional Information Related to the Gestalt Model

- **Organismic theorist** – A theorist who views developmental changes as qualitative (not empiricist: quantitative).
- After World War I, Perls worked with **Kurt Goldstein** at the Goldstein Institute for Brain-Damaged Soldiers in Frankfurt, Germany. This exposure showed Perls the importance of viewing a person as a whole being rather than as a sum of separately functioning parts (Corey, 2001).

TRANSACTIONAL ANALYSIS

I. Major Figures

Eric Berne

Thomas A. Harris

II. Overview of the TA Model

- Berne began in the Freudian tradition but realized the limitations of the classical method in which he was trained as he conducted group therapy during World War II and afterwards. He sought a more “rational” approach that would prove less dependent on the unconscious. His ideas evolved from his experiences and from his work with **Dr. Wilder Penfield**, neurological researcher at McGill University. By this time, Berne was also reading **Carl Rogers**.
- Berne discovered his parent-adult-child equivalents in Freudian psychoanalysis. Penfield’s research provided the neurological basis for the assumption that people exist in different ego states simultaneously and that these states are connected to memories. Rogers work rejected the Freudian diagnostic model and accepted the client as a rational, capable person. Thus, the theory and practice of transactional analysis was born (Belkin, 1987).

III. Goals of TA Treatment

- The goal of therapy is to assist the client in becoming a script-free, game-free, autonomous person who is capable of choosing how he/she wants to be.
- Additionally, therapy is to assist the client in examining early decisions and making new decisions based on awareness.

IV. Role of the TA Counselor

- The TA counselor is a joint, equal partner in the contractual counselor/client relationship.
- The counselor functions as teacher, trainer, and resource person.
- The client contracts with the therapist for the specific changes desired; when the contract is completed, therapy is terminated.
- Transference and dependence on the therapist are de-emphasized.

V. Normal Development

TA asserts four life positions which replace explicit psychopathology. These positions are developmental and associated with growth:

1. I'm not OK—You're OK
2. I'm not OK—You're not OK
3. I'm OK—You're not OK
4. I'm OK—You're OK

1. I'm not OK – You're OK

The infant's earliest response to the world is "I'm not OK—You're OK." The infant feels inadequate, incompetent, and, in Adlerian terms, inferior. The outside world is more competent and able to provide stroking (emotional nurturing). If this position continues into later life, the person is self-abusive, self-mutilating, and often suicidal—all masochistic characteristics.

2. I'm not OK—You're not OK

As the infant attempts to become more autonomous, he or she may evolve into the second position, "I'm not OK—You're not OK." Independence increases; stroking decreases. This is a difficult position. If no growth and warmth exists, the child may become stuck in this position, a most hopeless and pessimistic position. Schizoid behavior may result, and in extreme cases, the tendency to kill another and then kill oneself may surface.

3. I'm OK—You're not OK

If a child is continually brutalized by the parents he or she once felt were OK, the child will switch positions to the third position of "I'm OK—You're not OK." Adolescent delinquents and adult criminals are found here feeling victimized and paranoid. He or she distrusts everyone and sees this posture as survival. Extreme cases will engage in homicidal behavior as an acceptable solution to problems in life.

The first three positions are based on feelings.

4. I'm OK—You're OK

The fourth position is conscious, rational, and verbal and based on "thought, faith, and the wager of action" (Harris, 1995). The "I'm OK—You're OK" position is one of hopefulness and health marked by successful interpersonal relationships, feeling good about ourselves, feeling that we deserve the best, that we can attain the best. This position is roughly equivalent to Freud's ideal of full psychosexual development and sublimation.

VI. Development of Behavioral Disorders

- Maladaptive behavior results from an individual staying in one of the first three life positions.
- Misdirected early decisions can cause later problems.

VII. Applications of the TA Model

- This approach can be applied to parent-child relations, to the classroom, to group and individual counseling and therapy, to grandparent counseling, and to marriage counseling.
- This approach has been useful in treating passive-aggressive personality disorders and anorexia nervosa.

VIII. Suitability of the TA Model in Multicultural Settings

- Suitable for:
 1. Cultures that value autonomy
 2. Defining ego states within particular cultural frameworks
- Not suitable for:
 1. Cultures desiring directive, authoritarian counseling
 2. Cultures that value yielding to authority and holding to tradition

IX. Key TA Concepts and Terminology

- The person has potential for choice; people can shape their own destiny (antideterministic view).
- What was once decided can be redecided.
- Although the person may be a victim of early decisions and past scripting, self-defeating aspects can be changed with awareness.
- The focus is on games played to avoid intimacy in transactions.
- The personality is made up of **three ego states**:
 1. **Parent** – made up of admonitions, values, instructions, attitudes, and behavior handed down from parents or authority figures (also called the exteropsyché; resembles Freud's superego).
 - a. **Nurturing Parent** – supports, cares, encourages
 - b. **Critical Parent** – finds fault, is critical and harsh; shoulds, oughts, musts
 - c. **Prejudicial Parent** – opinionated, biased with no factual basis
 - d. **Incomplete Parent** – parent is absent or dies
 2. **Adult** – objective, logical, nonemotional, thinking, rational; deals with reality; assimilates and evaluates information based on facts; keeps Parent and Child ego states in balance (also called the neopsyché; resembles Freud's ego).
 3. **Child** – Source of childlike (not childish) behaviors (also called the archaeopsyché; resembles Freud's id); contains three aspects:
 - a. **Adapted child** – controlled, cries, rebels, is a product of demands
 - b. **Natural child** – untrained, spontaneous, impulsive, self-loving, expressive, pleasure-seeking
 - c. **Little Professor** – intuitive wisdom

Clients are taught how to recognize which ego state they are functioning in with given transactions.

- **Games** – a series of stereotyped and predictable patterns of behavior that end with surprise bad feelings for at least one player (Corey, 2001); prevent intimacy.
- **Rackets** – a habitual feeling that is clung to after a game (depression, guilt, anger).
- **Collecting trading stamps** – behaving so as to secure rackets.
- **Life Scripts** – personal life plan born out of early decisions about self, others, and the world.
- **Parental injunctions** – messages, both verbal and nonverbal and usually negative, that let a child know what to do to gain recognition.
- **Early decisions** – conclusions about self and life reached by age 5 aimed at survival, recognition, and attention. Games are formulated to support these early decisions.
- **Stroking** – any recognition whether positive, negative, conditional, or unconditional.
- Early decisions, scripting, and injunctions are key concepts.

X. Techniques Specific to the TA Model

- Many techniques of TA and Gestalt can be fruitfully combined.
- Some type of diagnosis may be useful to assess the nature of a problem.
- The client participates actively in diagnosis and interpretations and is taught to make his/her own interpretations and value judgments.
- **Confrontation** is often used to point out inconsistencies.
- **Questioning** is a basic part of TA. Interrogation requires answers from the adult ego state.
- **Explanation and illustration** are used to teach the adult ego state.
- **Interpretation** in TA is explaining to the client's child ego state reasons for the client's behavior.
- **Contracts** are essential and follow a **four step process** which equips the client to decide what to change:

STEP 1 – STRUCTURAL ANALYSIS OF THE PERSONALITY: The counselor and client examine the content and functioning of the three ego states.

STEP 2 – TRANSACTIONAL ANALYSIS: Three types of transactions are studied:

1. **Complementary** – a specific ego state sends a message, a specific state responds (adult/adult transaction)
2. **Crossed** – a sent message receives an unexpected response (adult/child transaction)
3. **Ulterior** – the overt message is different from the covert message

STEP 3 – GAME ANALYSIS: Examines transactions that result in negative feelings; these often award a negative feeling as a “payoff” of sorts, e.g. the **Karpman Drama Triangle** with its **Persecutor**, **Victim**, and **Rescuer**. There are actually three levels of games or ulterior transactions that appear to be complementary:

1. First degree games – played in social situations and cause mild upsets.
2. Second degree games – played in more intimate circles and lead to seriously hurt feelings.
3. Third degree games – usually end in jail, the hospital, or the morgue because of the violence involved.

STEP 4 – SCRIPT ANALYSIS: The life plan is reviewed with the view of revising life scripts so that self-control and congruency can be achieved.

The script-analysis checklist or questionnaire is useful in recognizing early injunctions. A life script will encompass life position, rackets, and games. Examples of life plans include:

- “Always” scripts that keep the person continuing on without any change.
- “Until” scripts which keep the person waiting to deserve a reward or change.
- “Never” scripts which keep a person believing he or she will never do better.
- “After” scripts keep a person anticipating a change after an expected occurrence.
- “Open-ended” scripts keep a person floating directionless after an event or time.
- “Ideal” scripts have the person feeling “I’m OK—You’re OK.”

XI. Criticisms of the TA Model

- Does not contain affective exploration.
- TA counselors must incorporate other approaches such as gestalt therapy to fill this gap.

XII. Additional Information Related to the TA Model

- **Eric Berne** wrote *Games People Play* and *What Do You Say After You Say Hello?*
- **Thomas A. Harris** wrote *I'm OK—You're OK*.
- **Claude Steiner** describes three unhealthy scripts in his book *Scripts People Live*.
They are:
 1. No love
 2. No mind
 3. No joy

BEHAVIORAL THERAPY

I. Major Figures

Classical Conditioning Respondent Conditioning	Operant Conditioning Instrumental Learning	Vicarious Conditioning Social Learning Theory
Ivan Pavlov	B.F. Skinner	Albert Bandura & Richard Walters
Joseph Wolpe	David Premack	Julian Rotter
William H. Masters & Virginia Johnson	Neal Miller	John Dollard & Neal Miller
Andrew Salter	Edmund Jacobson	George Kelly
Hans Selye		

II. Overview of the Behavioral Therapy Model

- Behavioral therapies comprise a body of related approaches held together by the common belief that emotional, learning, and adjustment difficulties can be treated through a variety of prescriptive, mechanical, usually nondynamic techniques and procedures.
- Through the last century, behavioral approaches have evolved in **four basic directions**:
 - Classical (respondent) conditioning**
 - Operant (instrumental) conditioning**
 - Social learning**
 - Cognitive behavior therapy**
- All share some basic concepts, but each brings a distinguishing focus or addition to the field.
- This chapter will discuss:
 - classical (respondent) conditioning,
 - operant (instrumental) conditioning, and
 - social learning or modeling.

Ellis' Rational Emotive Behavior Therapy and **Beck's** Cognitive Therapy are discussed separately in the next two sections. **Arnold Lazarus'** Multi-modal behavior therapy is covered in the section on eclectic therapies.

III. Goals of Behavioral Therapy Treatment

- Classical conditioning, operant conditioning, and social learning therapies all endeavor to eliminate inappropriate or maladaptive behaviors and to teach more effective ones.
- The focus is on meeting treatment goals which the client and counselor have evaluated and set.
- A baseline measurement is a requirement of behavioral therapy so that behavioral change can be objectively measured.

IV. Role of the Behavioral Therapy Counselor

- The counselor takes a teacher/trainer role and can model behavior.
- The counselor must establish a good working relationship with the client in order for the evaluating of old behaviors and the teaching of new behaviors to be accepted by the client.

V. Normal Development

- **Classical conditioning** asserts that human responses are elicited from the pairing of stimuli.
- **Operant conditioning** asserts that new responses are based on the reinforcement given.
- **Social learning**, which is in effect a form of sensory conditioning, asserts that new responses come from observing behaviors in others.
- Note that the cognitive-behavioral approaches add the function of cognitive processes. What one thinks influences behavior.

VI. Development of Behavioral Disorders

- Maladaptive behavior results from faulty learning/conditioning.

VII. Applications of the Behavioral Therapy Model

- Behavioral therapy is widely used in individual, group, and family and marital counseling and with all age groups including children and geriatric clients.
- The broad range of behaviors which behavior therapy can address include the following:
 - Stress and anxiety and their associated problems
 - Migraine headaches
 - Insomnia
 - High blood pressure
 - Asthma
 - Phobias
 - Anorexia nervosa
 - Compulsions
 - Depression
 - Traumatic memories
 - Assertion training
 - Self-management issues including drinking, smoking, taking drugs, time-management, and overeating.
 - Sexual disorders
- Examples of specific techniques used in treating particular behaviors:
 1. **Agoraphobia** – Graded exposure and flooding.
 2. **Alcoholism** – Aversive therapy (Antabuse).
 3. **Phobias** – Systematic desensitization for simple phobias.
Social skills training for shyness and fear of other people.
 4. **Schizophrenic disorders** – Token economy and social skills development.
 5. **Sexual dysfunctions** – Relaxation, desensitization, and graded exposure techniques.
 6. **Obsessive compulsive disorder (OCD)** – Flooding.

VIII. Suitability of the Behavioral Therapy Model in Multicultural Settings

- Suitable for:
 1. Cultures wanting a behavior focus rather than a feelings approach.
 2. Clients willing to participate in the goal decisions.
 3. Clients willing to accept the resulting consequences of new behaviors.
- Not suitable for:
 1. Clients needing to deal with underlying emotional issues.
 2. Clients in cultures in which behavior changes are discouraged.

IX. Key Behavioral Therapy Concepts, Terminology, & Major Figures

CLASSICAL CONDITIONING / RESPONDENT CONDITIONING

A. Ivan Pavlov

Classical Conditioning is a product of **Ivan Pavlov** and his study of behavior based upon dogs in the early 1900's. Before conditioning, the dog food (UCS) produces salivation (UCR). During conditioning, the dog food (UCS) is paired with a ringing bell (neutral) so that the bell becomes the conditioned stimulus (CS) producing salivation (CR). After conditioning, the bell (CS) produces salivation (CR).

Classical conditioning is mechanistic and deterministic. The client is passive.

- Important Terms associated with **Classical Conditioning**:

1. **Acquisition** – the period during which the organism learns the association between the conditioned stimulus and the conditioned response.
2. **Chaining** – the chaining together of a sequence of behaviors to produce a more complex behavior; the phenomenon of each response acting as the stimuli for the next response; used by behaviorists to explain complex behaviors.
3. **Conditioned Response (CR)** – the learned response to a conditioned stimulus.
4. **Conditioned Stimulus (CS)** – a stimulus that, through repeated pairings with an unconditioned stimulus (UCS), acquires the capacity to evoke a response it did not originally evoke.
5. **Counter-conditioning** – occurs when a negative conditioned stimulus is paired with a pleasant stimulus that elicits a response that is incompatible with the unwanted conditioned response.
6. **Stimulus discrimination or differentiation** – learning to make distinctions among similar stimuli.
7. **Experimental neurosis** – emotional disturbance that shows when two or more stimuli cannot be differentiated.
8. **Extinction** – the reduction in response that occurs when the conditioned stimulus is presented without the unconditioned stimulus. Often, the response will increase or worsen (called a response burst or extinction burst) before it is eliminated. (This parallels the stage in Operant Conditioning when reinforcement is no longer given.) A counselor must weigh the importance of the response burst factor when attempting extinction of self-mutilating or self-abusive behaviors.
9. **Higher order conditioning** – the process whereby a new stimulus is paired with the CS and takes on the associative power of the CS (dog salivates at bell; then light is paired with bell; dog salivates at light).
10. **Stimulus Generalization** – the showing of a given behavior toward similar stimuli once an organism has learned to associate a given behavior with a specific stimulus; Pavlov termed this irradiation (Little Albert's fear of anything furry, including Santa Claus).
11. **Spontaneous Recovery** – the recurrence of the previously extinguished conditioned response following a rest period.
12. **Unconditioned Response (UCR)** – a response that occurs to an unconditioned stimulus automatically without requiring any learning.
13. **Unconditioned Stimulus (UCS or US)** – a stimulus that naturally and automatically elicits an unconditioned response.

B. Joseph Wolpe

- **Systematic Desensitization.** **Joseph Wolpe** (1969) maintained that all neurotic behavior is an expression of anxiety. By using counter-conditioning, the anxiety-producing power of the stimulus can be weakened and the symptom of anxiety controlled and eliminated through stimulus substitution of the positive incompatible response.
- This technique is useful for phobias, neurotic anxieties, generalized fears, sexual dysfunctions, and interpersonal anxiety producing situations and is excellent for group use. This technique is not helpful for free-floating anxiety (anxiety with no identifiable stimulus).
- Systematic desensitization uses relaxation training as a counter-condition to anxiety. This is known as **reciprocal inhibition**: two opposite responses cannot exist simultaneously.
- The **subjective units of distress scale (SUDS)** allows the client to rate threatening experiences in relation to the scale with higher ratings indicating a greater perceived threat. A treatment hierarchy is then developed with the first action involving the least amount of anxiety.
- These steps are sequenced in systematic desensitization:
 1. Relaxation training
 2. Construction of the anxiety hierarchy (SUDS) – best if hierarchy items are evenly spaced
 3. Desensitization in imagination - This may be called interposition - implying that one thing covers or hides another as in relaxation hiding the anxiety.
 4. In vivo desensitization - This should not start until 75 percent of the hierarchy has been subjected to desensitization.

C. William H. Masters and Virginia Johnson

Masters and Johnson (1966) developed **sensate focus**, a form of behavioral sex therapy relying on counterconditioning. Couples engage in lower anxiety activities (touching and caressing) and then gradually progress in future encounters to intercourse.

D. Eye Movement Desensitization and Reprocessing (EMDR)

Francine Shapiro (1995) experienced traumatic memories being abated when her eye moved from side to side on a walk in the park. From this experience, she formulated the eight steps that comprise EMDR, a form of exposure therapy. EMDR has particularly been studied with posttraumatic stress disorder (PTSD) treatment and has received “probably efficacious for civilian PTSD” treatment status from the APA.

E. Andrew Salter – Reflex Therapy

- Inhibition (the blocking or clogging of emotions) is the cause of all psychological problems, so the focus of treatment is the removal of inhibitions through reconditioning via verbal expression of emotions. Salter called this verbal expression excitation and meant the spontaneous expressing of both positive and negative emotions (Salter, 1949).
- Wrote *The Case Against Psychoanalysis* and *Conditioned Reflex Therapy* from which assertiveness training was formulated.
- Assertiveness training utilizes **behavioral rehearsal** as a technique. This is role playing based on a hierarchy of situations requiring assertiveness.

F. Hans Selye – Stress

Selye's (1956) research indicated that stress is a part of life. How one copes leads to ease or disease. The following are the three stages of the General Adaptation Syndrome (G.A.S.) or the biological stress syndrome:

1. **Alarm Reaction** – The body produces a physiological response to a stressor.
2. **Stage of Resistance** – The body mobilizes to overcome or escape stress.
3. **Exhaustion** – Failure to resolve stress leads to physical/psychological exhaustion, **possibly even death.**

Other Important Terms Associated with Classical Conditioning

1. **Exposure therapy** includes desensitization, in vivo desensitization, flooding, and implosive therapy.
2. **Flooding** – is based on the premise that escaping from an anxiety-provoking experience reinforces the anxiety through conditioning. Thus, by not allowing the person to escape, anxiety can be extinguished, and the conditioned avoidance behavior can be prevented. The client is deliberately **confronted with the feared situation**. No relaxation exercises are used. The client experiences the fear which gradually subsides after a period of time. “Deliberate exposure with response prevention” defines flooding.
3. **Implosive Therapy** – is the forming of very vivid **images** of specific situations that cause the fear. Implosive therapy differs from flooding because the client is not exposed to the actual stimuli. T. G. Stampfl discovered implosive therapy.
4. **Aversive Therapy** – is a form of Classical conditioning which involves the use of punishment reinforcement and is sometimes called in vivo aversive conditioning. The goal is to eliminate problem behaviors by subjecting the client to pain or nausea (Example: Some smoking cessation programs; antabuse for alcoholism; use of electric shocks). The ethics are questionable since people have died from such treatments.
5. **Relaxation Therapy** – teaches the client how to control tension. Jacobson’s progressive relaxation techniques are popular.
6. **Assertiveness training** – based in counter-conditioning; would be considered a classical conditioning approach.

Note: Flooding and implosive therapy do not always work. They have been known to make behaviors worse.

OPERANT CONDITIONING / INSTRUMENTAL LEARNING

A. Skinner

- **Operant Conditioning** is the product of **B.F. Skinner** who researched using rats. Also referred to as **Instrumental Learning**.
- The client is an active participant. Reinforcement and proper timing are required for learning to take place.
- The term **behavior modification** is associated with operant or Skinnerian conditioning, as opposed to **behavior therapy** which is Pavlovian or classical.
- In Operant Conditioning, the behaviors increase or decrease in frequency as the result of the application of or withdrawal of rewards; this is known as **reinforcement**.

1. Types of Reinforcements:

- a. **Positive** – a consequence that is added, thereby strengthening the response that precedes it by virtue of its presentation. (**Examples:** stickers on good school work; payment for work; compliments for accomplishments)
- b. **Negative** – a consequence that is withdrawn or terminated thereby strengthening the response that precedes it by virtue of its removal or termination. In other words, when a negative event is removed, the desired behavior takes place. (**Examples:** 1) Being released from detention hall early for good behavior. 2) Skinner's rats were continuously shocked until they pushed a bar that turned off the current. Turning off a shock is a negative event because it takes away a stimulus. Since removal of the shocks increases the likelihood that a rat will push the bar again, the event is reinforcing.)
- c. **Primary** – an event with reinforcing qualities that are barely dependent, if dependent at all, on prior learning. (**Example:** food).
- d. **Secondary** – an event that is not inherently pleasant or reinforcing but it becomes so through its association with other reinforcing stimuli. (**Example:** money – currency is not in itself reinforcing, but the products money can buy are; token economies work the same way)
- e. **Partial or intermittent** – reinforcement that occurs only sometimes, not every time the desired response is given.
- f. **Punishment** – an aversive stimulus used repeatedly to produce avoidance behavior. Skinner did not believe punishment was effective in that it did not cause behavior to be unlearned, merely temporarily discontinued.

2. Schedules of Reinforcement

Timing and timeframes are key factors in operant conditioning. The chosen schedule or rate of reinforcement profoundly affects the rate of response. Any discussion or explanation of operant behavior must take time into account (Fogiel, 1980).

Half a second or slightly less is the most effective time interval between the CS and the US. In **delayed conditioning**, the CS continues until the UCS occurs and then stops with it. In **trace conditioning**, the CS continues for a short time and then stops and then the UCS occurs. Some texts use the term “forward conditioning” to denote the CS preceding the UCS. “Backward conditioning” is sometimes used to denote putting the UCS before the CS. Placing the UCS before the CS has proven highly ineffective.

Reinforcement can be presented in a continuous or an intermittent (intermittent or partial) pattern. Continuous reinforcement schedules, where each correct response is reinforced, are rarely employed because they yield the worst long-term learning results.

Therefore, schedules of reinforcement are considered to be established plans for allotting reinforcements under partial or intermittent schedules. Partial or intermittent (sometimes called thinning) reinforcement can be scheduled in these four formats:

- a. **Fixed-interval schedule:** Reinforcement is given after a certain fixed period of time. The amount of work done (the number of responses) does **not** affect when reinforcement is given. In other words, the reinforcement is given at a set time (or a set time period) regardless of how much work is done.
EXAMPLE: Generally speaking, people who receive a salary fit this category. They receive a paycheck at a specific time each month regardless of the amount of work they do. They do not get their paycheck earlier by standing around at the payroll window or by repeatedly asking/begging to get it early. They are paid (reinforced) at a pre-determined time or at a fixed interval.
- b. **Variable-interval schedule:** Reinforcement is given at variable (unpredictable) intervals of time. **EXAMPLE:** Let’s say you are attempting to call a friend and get a busy signal several times. So, you begin to place the call based on your best “guess” of when he/she will be off the line. But no matter how often or when you dial, the length of time (the variable) your friend stays on the phone (let’s say 7 minutes) determines when you will be rewarded (i.e., finally reach your friend). The next time the phone line is busy, he/she may be on the phone 3 minutes, and then you get rewarded. The following time he/she may be on the phone 13 minutes.
- c. **Fixed-ratio schedule:** Reinforcement is given after a set number of responses are performed. **EXAMPLE:** Let’s say you are hired to sew short sleeve shirts and are told you will be paid after completing every twelfth shirt. Upon completion of the 12th shirt, you are paid (being reinforced). You are not paid after the 3rd shirt, the 7th shirt, or the 9th shirt. You are paid only after you sew 12 shirts, 24 shirts, 36 shirts, etc.
- d. **Variable-ratio schedule:** The number of responses required before being reinforced is unpredictable/continually changing. **EXAMPLE:** Let’s say you are sitting at a slot machine putting in quarters. You know that there is a chance of winning. However, you don’t know how many quarters you’ll have to put in before winning. Sometimes you win after 7 quarters. Sometimes you win after 777 quarters. Sometimes you win after 7,777 quarters.

3. Other Important Terms associated with Operant Conditioning:

- a. **Successive approximation** – increments of change toward a desired behavior are reinforced, thereby **shaping** the response into the desired behavior (**Example:** Language development – a baby makes a small sound, mom smiles and says words that sound like the infant's. This continues until the infant makes a sound that is a recognized word.)
- b. **Token Economy** – a medium of exchange for the giving or withdrawing of positive reinforcers. The objects that the token “purchase” are sometimes referred to as **back-up reinforcers**.
- c. **Contingency Contracting** – is a behavior management technique. The consequences of using the target behavior are decided in advance and written in a contract. This technique is used primarily in school settings.
- d. **Time Out** – is an Operant conditioning technique. A "time out" room (where there are no rewarding stimuli) is used when undesired behavior is manifested. This is also used in school settings.
- e. **Groups created to facilitate behavior practice** – provide reinforcement for the participants' behavior. (**Examples:** groups dealing with weight loss, negative addictions, assertiveness training, and communication skills)

B. David Premack

The Premack principle proposes that high-probability behavior (HPB) can be used to positively reinforce a low-probability behavior (LPB), and engaging in a low-probability behavior can function as a punishment stimulus for a high-probability behavior. Parents use this principle when they tell children they must first do their chores and then they may play (Corsini, 1984).

C. Neal Miller

- **Neal Miller** was a pioneer researcher in biofeedback and learning theory. He was the first to show that autonomic (involuntary) bodily processes can be controlled.
- Biofeedback is a form of operant conditioning.
- A biofeedback device provides biological information. These devices can be sophisticated electronic devices or an object as simple as a mirror.
- Landmark research in biofeedback has been performed at the Menninger Clinic in Kansas. One of its discoveries is that raising the temperature in the right hand can prevent or stop a migraine headache. A temperature trainer (an expensive but precise thermometer) is used in this biofeedback training.
- An electromyogram (EMG) is used to measure muscle tension during biofeedback training.
- An electroencephalogram (EEG) is used to measure alpha brain waves which indicate that the client is awake but very relaxed.
- An electrocardiogram (EKG) is used to measure the heart rate and pattern.
- Galvanic skin response (GSR) measures skin resistance to a slight electrical current when certain words or topics are brought up.

D. Edmund Jacobson

- **The Jacobson Relaxation Method** (1974) involves a tensing and relaxing of groups of muscles until the whole body is relaxed. It is praised for its simplicity and effectiveness.

VICARIOUS CONDITIONING / SOCIAL LEARNING THEORY

Also known as: Observational Learning
Linear-Interactionist Social – Cognitive Theory
Cognitive Social Learning Theory

Social learning theory bridges operant behaviorism and humanistic theory by acknowledging the interaction between environmental influence and the nature of people.

The client is an active participant. Both imitative and emotional learning take place.

A. **Albert Bandura and Richard Walters** (Bandura, 1977)

- This is a Socio-behavioristic approach
- They emphasized Modeling – BoBo Doll experiment on children modeling aggression
- It is an Observational-learning theory
- They used "in vivo" exposure to confront threatening situations and personal expectations
- Four processes in observational learning:
 1. Attentional processes
 2. Retention processes
 3. Motor reproduction
 4. Incentive and motivational processes
- Modeling is enhanced by the nature of the model, the observer, and the presentation of the behavior.
- **A model** should be similar to the observer in age, race, sex, and attitudes. A model should appear competent and of an appropriate level of prestige, warmth, and care. The perceived rewards received by the model will also influence the observer.
- **An observer** must be able to process what he observes and retain that information. The observer's level of anxiety and uncertainty regarding the behavior to be modeled must be moderate enough not to block the process and yet high enough to optimize learning.
- **The presentation** can take many forms: live, symbolic, multiple, covert, a coping model, a learning model, an expert at the behavior. Graduated procedures may be used; instruction may be given; rules may be made; summarizing by the observer may be required.

B. Julian Rotter (Hunt, 1993)

- Expectancy-reinforcement theory
- Developed a system of constructs to provide maximum prediction and control of behavior.
- Three basic constructs are:
 1. Behavior Potential – Potential for specific behavior to occur in a given situation.
 2. Expectancy – Expectancy by a person that certain reinforcements will follow certain behaviors.
 3. Reinforcement Value – Degree of preference for any one of several possible reinforcements when all are equal.
- Rotter theorized that behavior problems result when a behavior is avoided because either a punishment was previously associated with that behavior or satisfaction is attained through inappropriate means.
- A maladjusted person expects his or her maladjusted behavior to lead to greater gratification than would be expected by a mentally healthy individual.
- Therapy is geared to the gratification expected: lowering the expectancy of gratification for maladjusted behavior and increasing the expectancy of gratification of alternative behavior.
- Techniques include direct reinforcement, observing models, discussing observed behaviors, dealing with prior negative reinforcements, introducing alternative behaviors, and suggesting and reinforcing expectancy that the client has the capacity to identify and test alternative behaviors, etc.

C. John Dollard and Neal Miller (Dollard & Miller, 1950)

Reinforcement Theory

- Reinforcement theory is an integration of psychoanalytic principles, Hullian behaviorism (Clark Hull's mathematically-oriented theory of motivational processes (drive), and social learning theory. Whereas Bandura considered responses to be innate, Dollard and Miller said that responses are learned.
- All learning entails these four elements:
 1. **Drive (motivation)** – Either internal or from the environment; can be innate or learned.
 2. **Cue (a discriminative stimulus; what a person notices)** – Either internal or external; sets a response in motion and guides that response; determines “when [an individual] will respond, where he will respond, and which response he will make” (Miller & Dollard, 1941).
 3. **Response (the resulting behavior)** – In any given situation, an individual will have a multitude of possible responses to choose from. The person's prior learning-reinforcement history will have ingrained responses with different response strengths. The dominant or strongest response is the most likely to manifest.
 4. **Reinforcement (the reward for the behavior)** – Since the drive is satisfied, the reinforcement is a drive-reduction factor. All reinforcers reduce drive.
- To Dollard and Miller, the personality is the system of habits that an individual develops in response to cues in the environment. Behavior is motivated by primary (survival needs) and learned drives. The habits that are reinforced tend to be repeated and thereby become part of the stable collection of habits that constitute personality.
- **Four types of conflict situations:**
 1. **Approach-approach:** Choosing between two desirable goals.
(**Example:** Choosing between two good job offers)
 2. **Approach-avoidance:** Approach and avoidance of the same goal.
(**Example:** Wanting to eat but not wanting to gain weight)
 3. **Avoidance-avoidance:** Conflict around two undesirable goals.
(**Example:** Washing a load of dishes or vacuuming the house)
 4. **Double Approach-avoidance:** Conflict involving both the approach and the avoidance of two different goals simultaneously.
(**Example:** One's attraction to a larger, newer house with higher payments and an attraction to a smaller older house with smaller payments)

- Reinforcement theory is based on **six conflict behavior assumptions**:
 1. The inclination to approach a goal strengthens the closer a person gets to the goal.
 2. The inclination to avoid a feared goal (stimulus) strengthens the closer a person gets to the feared goal.
 3. The strength of avoidance increases more quickly than the strength of approach.
 4. An increase in drive increases either/both approach and avoidance.
 5. The strength of a response (either approach or avoidance) is influenced by the history of reinforcement.
 6. Two simultaneous, conflicting responses will result either in the stronger response occurring or in a stalemate causing neurosis.
- Dollard and Miller asserted that neurosis develops when conflict from two or more strong drives results in incompatible responses.
- Therapy is viewed as a new learning arena in which both psychoanalytic and behavioral techniques assist the client in extinguishing neurotic responses and in learning better, more constructive responses. The restoration of the higher mental processes is the goal.
- Better responses will follow when the client learns to remove repression, to implement relationship transference, to label, and to discriminate.
- Common techniques include counselor permissiveness, free association, full attention and acceptance from the counselor, interpretation of silence, confronting avoidance, reframing, labeling, rehearsing responses, identifying similarities and differences in responses, etc.

D. George Kelly

- **Kelly's (1955) system of personal constructs** is based on Kelly's belief that an individual's own concepts or constructs are created by the individual in an effort to understand the individual environment.
- **Constructive alternativism** is an important determinant of one's decisions and behavior.
- Kelly's **fixed role therapy** comes from his **psychology of personal constructs** and involves giving a client an outline sketch or a fixed role. The client is to read the role at least three times a day and act, think, and talk like the role.

X. Techniques Specific to the Behavioral Therapy Model

- All of the techniques mentioned in this behavioral therapy section are applicable.
- Diagnosis and assessment are important tools in establishing a baseline from which to go forward with a treatment plan.
- The counselor and client consider the “what,” “how,” and “when” of behaviors but not the “why.”
- Cognitive restructuring and dealing with the “why” of behavior are left to the cognitive-behavior and the multi-modal therapy approaches.

XI. Criticisms of the Behavioral Therapy Model

- The assessment of successful treatment depends many times on uncontrollable factors.
- The behavior therapy counselor can become quite controlling and manipulative.
- Behavior changes do not necessarily reflect changes in feelings or emotions.
- A client’s background and the cause of maladaptive behaviors is not considered a major treatment factor.
- Note that the cognitive-behavior therapy models generally do address these issues.

XII. Additional Information Related to the Behavioral Therapy Model

- Behavior therapy is Pavlovian, classical, respondent.
- Behavior modification is Skinnerian, operant, instrumental.
- Watson and Rayner’s **Little Albert experiment** was significant because it showed that a phobia can be a learned behavior.
- Mary Cover Jones was the first researcher to remove a fear from a child thereby demonstrating that learning could be a cure for a phobia.
- **Yerkes-Dodson Law**
The Yerkes-Dodson Law states that there is a level of arousal or stress connected to the optimal performance of an action or task. Too high a level of arousal or stress will block performance just as too low a level of arousal or stress (i.e., a little bit of test anxiety is beneficial and produces better performance).
- **Baseline** – a starting or reference point, figure, amount, level, etc. with which others can be measured or compared. In behavior therapy, the baseline is the frequency of behavior before or without conditioning.
- **Covert** – behavior that is not seen or observable (a thought or visualization).
- **Overt** – behavior that can be seen or observed.
- **In vivo** – in biology in vivo means in a living organism; in psychology the term refers to treatment of an overt behavior.

RATIONAL EMOTIVE BEHAVIOR THERAPY – (REBT) COGNITIVE BEHAVIORAL STYLE OF ALBERT ELLIS

I. Major Figure

Albert Ellis

II. Overview of the REBT Model

Ellis (1973) wrote

that people are not exclusively the products of social learning (as the theories of the psychoanalysts and the behavior psychologists emphasize) but that their so-called pathological symptoms are the result of biosocial learning. That is to say, because they are human...they tend to have several strong, irrational, empirically unvalidatable ideas; and as long as they hold on to these ideas...they will tend to be what we commonly call 'neurotic,' 'disturbed,' or 'mentally ill' (p. 123).

Simply put, one's feelings and actions are determined by his/her cognitions, the way one thinks.

III. Goals of REBT Treatment

- A. REBT is unequivocally directive and intentionally attempts to "lead" the client to a "healthier" perspective.
- B. Clients learn to re-perceive or rethink their life events and philosophies and thereby to change their unrealistic and illogical thought, emotion, and behavior.
- C. Rational-emotive "teaching" empowers the client to analyze introspectively and to correct his or her distortion of the world.
- D. The client is taught to apply the scientific model to his or her own thought processes and behaviors.
- E. "Automatic" thoughts must be recognized and changed.

IV. Role of the REBT Counselor

- The counselor/client relationship is described as teacher/student and is not necessarily a personal relationship.
- The counselor is directive and authoritarian.
- The A-B-C model of changing cognitions is taught to the client.
- The therapist works to distinguish between understanding the patient and agreeing with his or her irrational perceptions. According to Ellis (1962), the therapist is to understand the client's behavior, no matter how immature, without getting involved in or believing in it.
- The counselor may inject his or her own values into the therapeutic process.

V. Normal Development

- While growing up, a child is taught to think certain thoughts and feel certain emotions about the self and others. The thoughts that are associated with the idea of "This is good!" become positive human emotions, such as joy or love. The thoughts associated with the idea of "This is bad!" become negative emotions and result in painful, negative, depressive feelings.
- Ellis emphasized that a person is born with the potential to be rational and logical but becomes illogical and influenced inordinately by "crooked thinking" because of distortions during childhood and continued contemporary repetitions of those distortions.

VI. Development of Behavioral Disorders

- A faulty belief system is at the root of emotional and behavioral disorders. Ellis's examples of faulty beliefs include the following:
 - A stronger someone is needed to lean on.
 - External events make a person happy or unhappy.
 - Every important person in one's life must show love and approval.
- Neurosis results from irrational or faulty thinking and behaving.
- Blame is the core of emotional disturbance.
- The client must learn to stop blaming and to accept him/herself in spite of imperfections.

VII. Applications of the REBT Model

- REBT has been successfully applied in individual, couples, family, and group counseling, especially where one problem is attacked.
- Such problems include character disorders, depression, psychotic disorders, anxiety, hostility, child rearing, social skills, and problems of love, sex, and marriage, etc.
- REBT is used successfully in many self-help programs.

VIII. Suitability of the REBT Model in Multicultural Settings

- Suitable for:
 1. Cultures open to a “thinking” approach (rather than an “exploring thoughts and feelings” approach)
 2. Cultures which want to avoid the stigma of mental illness and therefore will accept the teaching and learning of this approach.
 3. Exploring cultural conflicts.
 4. Clients who want to contribute and to participate in the therapy process.
- Not suitable for:
 1. Clients who tend to become dependent on the counselor for direction.
 2. Cultures which frown on questioning cultural beliefs and traditions.
 3. Clients who do not want such a structured approach.
- Cautions:
 1. Counselors should not encourage belief and behavior change before the client’s culture is understood by the counselor.
 2. The counselor should be aware that unconscious, underlying conflicts may need to be identified and dealt with.
 3. Since REBT does not rely on extensive client histories, the importance of past events may be downplayed or overlooked.

IX. Key REBT Concepts and Terminology

- People have the capacity for rational thinking but tend toward “crooked” thinking.
- People tend to accept (sometimes in childhood) and indoctrinate themselves with irrational thinking and then re-indoctrinate themselves over and over again.
- It is not the event, but rather it is one’s interpretation of it, that causes one’s emotional reaction.
- Faulty, irrational thinking can be changed by rethinking, questioning, deciding, doing, and redeciding. New skills can be mastered, new thinking patterns can be learned, and new coping skills can be acquired. REBT is psychoeducational.
- People make mistakes and must learn to accept that reality.
- People self-talk, meaning that they carry on internal dialogues which reflect their basic belief systems.
- REBT uses the A-B-C Theory of Emotional Disturbance (Ellis & Harper, 1997):

A = ACTIVATING experience

B = BELIEF about or the interpretation of the experience

C = upsetting emotional **CONSEQUENCES**

D = DISPUTING of irrational ideas

E = new **EMOTIONAL** consequence or **EFFECT**

F = new **FEELING**

An individual’s **Belief (B)** about the **Activating (A)** experience generates the upsetting emotional **Consequences (C)**.

Disputing (D) the irrational ideas **Beliefs (B)** is a process of:

- **detecting** irrational beliefs,
- **debating** the beliefs by challenging them logically, and
- **discriminating** between rational, self-helping beliefs and irrational, self-defeating ones.

(These three “D”s are known as the Scientific Method.)

New, **Effective (E)** philosophies are created along with new **Feelings (F)**.

X. Techniques Specific to the REBT Model

- Techniques are chosen for usefulness with a particular client or group.
- Cognitive, emotional, and behavioral techniques are all acceptable.
- REBT therapy is directive, active, and structured.
- The focus is on the present.
- The goal is to be effective and efficient thereby limiting the length of treatment necessary.
- Once a client has gained “insight” into his or her problems, the client must be proactive in changing thinking and acting that furthers self-defeat.
- **The course of therapy can be divided into three modes:**
 1. **Cognitive** – teaches the client “how to find his shoulds, oughts, and musts; how to separate his rational...from his irrational beliefs; how to use the logico-empirical method of science (the scientific method) in relation to himself and his own problems; and how to accept reality” (p. 196, Ellis, 1973).
 - Confrontation
 - Analyzing interpretations and forming alternate ones
 - Socratic dialogue
 - Debating or disputing irrational beliefs
 - Gathering data validating assumptions or misassumptions
 - Therapeutic cognitive restructuring: Rewording self-talk or internal verbalizations
 - Humor to point out absurd ideas
 - Homework assignments: Purposefully take risks
Reading a book (bibliotherapy) such as Ellis’ *A Guide to Rational Living*
 2. **Emotive** – dramatizes truths and falsehoods so that the client can clearly distinguish between the two:
 - Role playing
 - Modeling
 - Unconditional acceptance
 - Exhortation
 - Imagery
 - Shame attacking exercises
 - Forceful and vigorous responses
 3. **Behavior** – “helps the client change his dysfunctional symptoms and to become habituated to more effective ways of performing, and to help him radically change his cognitions about himself, about others, and about the world” (p. 197, Ellis, 1973).
 - Regular behavior therapy procedures: Operant conditioning
Systematic desensitization
Modeling
Self-management techniques
Relaxation techniques
Assertiveness training
 - Failing on purpose at something
 - Keeping a diary of activities
 - Changing thoughts and language
 - Practice new coping skills

Some REBT counselors speak of these modes as

Cognitive disputation – changing the client’s thinking

Imaginal disputation – using imagery to enhance the process

Behavioral disputation – pressing the client to change behaviors

XI. Criticisms of the REBT Model

- Counselors may promote dependence in the guise of being directive.
- The confrontational nature of REBT can cause a client to terminate counseling prematurely.
- The tendency of REBT is not to focus on the client's past or on underlying unconscious conflicts that may need to be dealt with.

XII. Additional Information Related to the REBT Model

- Epictetus (a Stoic philosopher) said, “Men are disturbed not by things, but of the view which they take of them.”
- Ellis also credited **Alfred Korzybski**, the founder of general semantics, **Karen Horney** with her “tyranny of the shoulds,” and **Adler's** recognition of social factors as influencing his formulation of REBT.
- Ellis believed that a person always has the ability and the power to improve or to lessen intense feelings of anxiety, despair, hostility, etc.
- *A Guide to Rational Living* by Ellis and Robert Harper is Ellis' best known work. He has published numerous other articles and books, including *How to Stubbornly Refuse to Make Yourself Miserable About Anything—Yes, Anything!*
- Ellis coined the term “**musterbation**” to describe a client who uses too many shoulds, oughts, and musts in thinking. The term “absolutist thinking” is sometimes used to describe this situation as well.
- Awfulizing, terriblizing, and catastrophizing are terms REBT counselors use to describe clients telling themselves how awful or terrible a situation really is.
- The word *didactic* means *teaching*. Therefore, REBT is a didactic model of therapy.
- REBT does not see transference as a valid concept (Neither do Glasser and the behaviorists).
- REBT was originally called Rational-Emotive Therapy (RET).
- **Maxie C. Maultsby, Jr.** (1984) formulated **Rational-Behavior Therapy (RBT)**, an approach similar to REBT.
 - RBT stresses the importance of a written self-analysis (REBT does not).
 - RBT is a useful model for self-help.
 - RBT is useful in multicultural, group, and substance abuse counseling.
 - RBT is a didactic model with the counselor teaching clients to use the techniques in their own lives.
 - The counselor is highly directive.
 - All group members are encouraged to participate in the sessions.
 - Homework assignments are given, especially bibliotherapy.
 - RBT is sometimes called Rational Self-counseling.

COGNITIVE THERAPY

COGNITIVE BEHAVIORAL STYLE OF AARON BECK

I. Major Figures

Aaron Beck

Donald Meichenbaum

II. Overview of the Cognitive Therapy Model

- Aaron Beck originally set out to validate Freud's explanation of depression as self-directed anger. He instead ended up rejecting Freud's motivational model and developed a cognitive theory of depression. Beck, calling himself an ex-psychoanalyst, identified "cognitive distortions" in the thinking of depressed individuals. These negative thoughts are based on underlying dysfunctional assumptions and beliefs. Beck went on to apply his concepts to other problems as well.
- Ellis and Beck arrived at their conclusions separately, but Beck gives Ellis credit for bringing forth the concept that feelings and behaviors can be changed by focusing on cognitive factors. Ellis regards Beck's research as very beneficial to the furtherance and the success of cognitive-behavioral therapies.

III. Goals of Cognitive Therapy Treatment

- Since distorted "rules" and "formulas for living" cause unhappiness in individuals, new rules must be experimented with and tested.
- "The remedy," according to Beck (1988, page 157), "lies in modifying the cognitive set. This psychological modification then produces biochemical changes which in turn can influence cognitions further."
- Cognitive distortions must be identified and discarded.

IV. Role of the Cognitive Therapy Counselor

- The core therapeutic conditions outlined by Rogers are necessary: genuine warmth, accurate empathy, nonjudgmental acceptance, the ability to establish rapport with the client, etc.
- In addition, the CT counselor **must** be active, creative, and able to engage the client in the therapeutic process.
- Therapy is a collaborative process between the counselor and client. Beck conceptualizes a partnership to formulate individually meaningful evaluations of the client's "distorted" assumptions (Beck & Haaga, 1992).

V. Normal Development

- As people grow up, they develop views of the connections between themselves and others, and the environment.
- These views become “rules” and “formulas for living.”
- To function appropriately, one’s perception of the world and one’s relationship with it should be consistent with the probable responses to one’s actions (Belkin, 1987).

VI. Development of Behavioral Disorders

- When the views people have of the connections between themselves and the environment become distorted, these distortions influence the way they feel about themselves and the way they perceive and process the world around them.
- Problems occur when an individual thinks dysfunctionally; ideas that are too broad or too absolute lead to problems like depression.

VII. Applications of the Cognitive Therapy Model

- Cognitive therapy has been successfully used with a wide and varied range of clients including individuals, groups, families, and children.
- CT has been applied to child abusers, parent training, substance abuse recovery, divorce counseling, marital counseling, and stress management.
- Many clinical conditions are treated with CT including eating disorders, borderline personality disorders, generalized anxiety disorder, social phobias, performance anxiety, posttraumatic stress disorder, adjustment disorder, chronic pain, suicidal behavior, narcissistic personality disorders, and schizophrenic disorders.
- Cognitive therapy is appropriate for both individual and group counseling including families, children, parent training, and child abusers.

VIII. Suitability of the Cognitive Therapy Model in Multicultural Settings

- Suitable for:
 1. Cultures valuing active intervention of the counselor.
 2. Cultures valuing the psychoeducational stance of the counselor.
 3. When the counselor understands the clients cultural values and worldview.
- Not suitable for:
 1. Clients with a tendency toward dependence on the counselor.
 2. Clients desiring less structure.

IX. Key Cognitive Therapy Concepts and Terminology

- People develop "common sense" by storing information concepts and formulas for dealing with problems.
- Their unique common sense and basic survival instincts form the basis for behavior.
- People live by “rules” and “formulas for living.”
- The way in which an individual structures and interprets his or her experience determines mood and subsequent behavior.
- Seeing and thinking negatively are argued to cause negative feelings and behaviors.
- Changing the manner in which an individual conceptualizes lies at the heart of the therapeutic procedure.
- Changing cognitive distortions can be done.
- **Cognitive distortions** are systematic errors in reasoning which result in misconceptions and faulty assumptions. Beck and his associates include the following as identified distortions (Beck & Weishaar, 1995; Dattilio & Freeman, 1992):
 1. **Magnification and minimization** – judging something as greater or less than it is.
 2. **Selective abstraction** – making assumptions based on one detail rather than the whole.
 3. **Arbitrary inferences** – making assumptions with no evidence to support it.
 4. **Labeling and mislabeling** – basing one’s identity on past mistakes or imperfections.
 5. **Polarized thinking** – going to either-or extremes or dealing in all-or-nothing terms.
 6. **Personalization** – relating an unrelated external event to oneself.
 7. **Overgeneralization** – adopting an extreme belief based on a single incident.
 8. **Incorrect assessments of danger or safety** – phobias or underestimating dangers.

X. Techniques Specific to the Cognitive Therapy Model

- Clients are taught to make self-assessments or self-observations to identify cognitive distortions.
- After clients have gained insight into how these distortions or unrealistically negative thoughts are affecting them, they are taught to evaluate these “automatic thoughts” by weighing them against reality, the evidence for and against the thoughts. This process involves techniques such as:
 - Socratic dialogue
 - Gathering data to validate or invalidate assumptions
 - Keeping a diary of daily activities
 - Formulating new, alternative assumptions or interpretations
 - Homework
 - Bibliotherapy
- Authoritative methods are avoided.

XI. Criticisms of the Cognitive Therapy Model

- Many critics feel that Cognitive therapy is too superficial, that it only deals with the here and now symptoms of a problem and not with the underlying causes of difficulties.
- Some say that CT simply emphasizes positive thinking instead of true change.

XII. Additional Information Related to the Cognitive Therapy Model

- Cognitive therapy resulted from Beck's research on depression.
- Beck developed the Beck Depression Inventory Scale (known as the BDI).
- Dr. Judy Beck, Aaron Beck's daughter, is now director of the Beck Institute, a research and training center. She actively promotes the approach.
- The term metacognition is sometimes used to refer to a person's awareness of his or her own cognitions or cognitive abilities.
- **Donald Meichenbaum** (1977) believes that the sequences of inner speech within everyone influence behavior.

Meichenbaum's **Cognitive Behavior Modification (CBM)**, also known as **Self-Instructional Therapy** – has three stages:

Stage 1 – The client is “educated” to observe his or her own behavior.

Stage 2 – The client is taught to change his or her self-talk, to rehearse new wording.

Stage 3 – The new self-talk is used in a real-life situation.

Meichenbaum's (1985) **stress-inoculation training (SIT)** prepares clients for intervention, motivates them to change, and attacks the issues of resistance and relapse. The coping skills in SIT can be applied to current and future situations.

REALITY THERAPY

I. Major Figure

William Glasser

II. Overview of the Reality Therapy Model

- William Glasser was trained in the psychoanalytic approach but became discouraged and objected to the psychoanalytic concepts of neurosis and mental illness. Instead of being ill, the client was weak, according to Glasser, and could be strengthened to become a contributing member of society (Glasser, 1965).
- Glasser decided that it was **not necessary to explore a patient's past history** in detail, and he **rejected** the notion of **transference**.
- Glasser also **rejected** the Freudian notion that **attaining insight into the unconscious** was necessary for mental health.
- Glasser arrived at his theory after working with troubled adolescents and went on to apply it to broader population groups.
- By the 1970's, Glasser was looking for a theoretical framework to explain his findings and work. He chose Control Theory originally espoused by William Powers (1973). By the mid-1990's, Glasser had expanded, clarified, and revised the theory and adopted the term **Choice Theory** to denote the connection between behavior and choice.

III. Goals of Reality Therapy Treatment

- The counselor must teach (Belkin, 1987) the client:
 1. to make appropriate choices
 2. to develop a sense of responsibility
 3. to be able to interact constructively with others
 4. to understand and accept the reality of his or her existence

IV. The Role of the Reality Therapy Counselor

- The counselor's most important task is to become a "friend" to the client.
- The counselor teaches clients to apply choice theory in their day-to-day living.
- The counselor follows the eight step counseling process which employs WDEP:
 - Wants and needs
 - Doing and direction
 - Evaluation
 - Planning and commitment....(See more at Roman Numeral X. – Techniques Specific to the Reality Therapy Model.)

V. Normal Development

- According to Glasser's **Choice Theory**
 1. We are born with five needs: survival, love and belonging, power, freedom, and fun.
 2. These needs have varying strengths and drive us for all of our lives.
- One's identity results from the interactions of the self, others, and the environment.
- Two critical developmental periods are identified:
 1. Ages 2 to 5 as socialization skills are learned. Love, acceptance, guidance, and support from parents are critical to the child's burgeoning success identity.
 2. Ages 5 to 10 as increasing interaction in the school environment can result in increased frustration and a resulting failure identity.

VI. Development of Behavioral Disorders

- Problem behavior stems from one of two avenues: neurological factors or choices.
 1. **Neurological factors** – Glasser uses the term “mental illness” to encompass conditions caused by brain abnormalities, brain damage, etc. e.g. Alzheimer's disease, brain infections, head trauma, and epilepsy.
 2. **Choices** – Behavior choices have been made in response to either a current unsatisfying relationship or to the lack of any relationship at all. Perhaps a person is trying to control others or is resisting being controlled by others. These problem behaviors are attempts to deal with the resulting pain and frustration. The resulting frustration leads to an individual adopting a failure identity. These choices are **not** “mental illness.”
- Glasser does not endorse assigning a diagnosis. He feels that a diagnosis just gives the client “permission” to continue to behave in that manner. Since Glasser rejects the traditional medical model of disease, he refrains from using either the DSM or the ICD (the International Classification of Disease) as guidelines.

VII. Applications of the Reality Therapy Model

- Reality therapy is well-suited to brief, short-term counseling.
- Reality therapy has been a popular approach in institutional settings including schools, correctional facilities, general hospitals, mental hospitals, substance abuse facilities, etc.
- Reality therapy has been successfully applied to counseling (individual, group, family, marital), social work, crisis intervention, education, community development, and institutional management (Corey, 2001).

VIII. Suitability of Reality Therapy in Multicultural Settings

- Suitable for:
 1. Clients willing to evaluate behavior based on their relationship to their culture.
 2. Clients wanting to retain their ethnic identity and yet needing to assimilate some characteristics of the larger culture in which they live.
- Not suitable for:
 1. Counselors and clients unwilling to evaluate and to acknowledge the role of racism and discrimination in the social and political arenas.
 2. Clients and cultures who insist on focusing on changing the environment.

IX. Key Reality Therapy Concepts and Terminology

- **Choice theory** asserts that the only behavior a person can control is one's own. A person controls himself/herself and makes choices to satisfy his/her wants and needs. (The abbreviation BCP stands for behavior controlled by one's perception.)
- People are all **responsible** for what they choose to do. Their value judgments and the choices they make based on those judgments determine their feelings.
- The past is only explored in terms of past successes. Reality therapy counselors believe that an emphasis on past failures only reinforces one's "failure identity."
- An individual may be a product of his or her past, but being a victim of the past is a choice.
- The focus is on the here and now. Problems are in the present, not the past or future.
- No excuses are accepted. Unconscious motives are not accepted as valid influences.
- **Addictions can be negative** (substance abuse, work) and therefore destructive or positive (jogging, swimming) and therefore self-confidence building in nature. A **positive addiction** involves a non-competitive, solo activity that can be carried out for about an hour a day.
- Mental health is determined in terms of one's identity. Individuals will develop either a success or failure identity. Achieving identity is a person's greatest psychological need.
- A success identity leads a person to feel their worth and significance to others. An irresponsible person will feel frustrated at attempting to feel love and worth and will then develop a failure identity and a skewed perception of reality evidenced by loneliness, withdrawal, delinquency, mental illness, etc. The cure is to assume responsibility for one's own happiness.

X. Techniques Specific to the Reality Therapy Model

- This approach is active, didactic, directive, supportive, and confrontational. The counselor chooses techniques which encourage clients to evaluate present behavior, formulate a plan to change behavior, and then commit and follow through.
- Glasser formulated an eight step counseling process (Glasser, 1980):
 - Step 1: The counselor establishes a **good working relationship** with the client, a friendship.
 - Step 2: Present behavior is identified in a noncritical way.
 - Step 3: The client evaluates or judges his or her behavior.
 - Step 4: Alternative behaviors are examined and a plan of action is developed.
 - Step 5: The counselor gains a commitment to the action plan from the client.
 - Step 6: No excuses or noncompliance are accepted; logical consequences are employed.
 - Step 7: The counselor holds the client to his or her commitment **without** employing **punishment**.
 - Step 8: The counselor and client **never give up** until the action plan is fulfilled.
- **Glasser and Wubbolding** (2000) later prescribed WDEP, an acronym referring to counseling procedural strategies:
 - Wants and needs** – By using directed questioning, the counselor leads clients to recognize and to define what they want and how they want their needs met.
 - Doing and direction** – The counselor asks, “What are you doing?” “What direction are you headed now?”
 - Evaluation** – The counselor asks, “Does your present behavior have a reasonable chance of getting you what you want now, and will it take you in the direction you want to go?”
 - Planning and commitment** – The counselor and client formulate and commit to a plan of action. A good plan will be simple, attainable, measurable, immediate, involved, controlled by the planner, committed to, and continuously done.

XI. Criticisms of Reality Therapy

- Reality therapy does not give weight to the client’s past, unconscious conflicts, transference, early childhood experiences, dreams, etc.
- More complex problems require other interventions (based in other therapies).
- Reality therapy can be perceived as being too simplistic, a “quick fix” instead of a real solution.

XII. Additional Information Related to Reality Therapy

William Glasser wrote: *Reality Therapy*
Schools Without Failure
Choice Theory

ECLECTIC THERAPY OR INTEGRATIVE THERAPY

I. Major Figures

Frederick Thorne	Robert Carkhuff
Arnold Lazarus	Gerard Egan
Gordon Allport	

II. Overview of the Eclectic Therapy Model

A. Roughly fifty percent of all counselors now consider themselves to be eclectic.

B. Two basic types of eclecticism are generally recognized:

1. **Counselor- or therapist-centered eclecticism** refers to counselors' choosing personal counseling systems that match their personalities and are, therefore, considered to be more effective. Gerald Corey encourages beginning counselors to become familiar with the major therapeutic approaches. He cautions, however, that the synthesis of ideas which will comprise an eclectic framework will come only after years of training, study, and actual counseling experience (Corey, 2001).

Arnold Lazarus emphasized the importance of choosing the appropriate technique or intervention for a particular client. Making an appropriate choice depends on the counselor's versatility, flexibility, and comprehension of available techniques (Lazarus, 1971).

2. **Process-centered eclecticism** emphasizes particular underlying factors as being common to all therapeutic interchanges. What works is more important than the theoretical basis from which the technique comes. The communication skill approaches are prime examples of process-centered eclecticism.

III. Goals of Eclectic Therapy Treatment

- An emphasis is the search for growth with a focus on health.
- There is a concern about the reduction of symptoms, but more emphasis is placed on better functioning.
- Eclectic therapy accentuates the positive.

IV. The Role of the Eclectic Counselor

- The eclectic therapist is a coach or trainer rather than a healer.

V. Normal Development

- No one single theory of development is followed.

VI. Development of Behavioral Disorders

- No one single theory of abnormal development is followed.

VII. Applications of the Eclectic Therapy Model

- Different therapy models must be chosen to meet the counselor's and the client's individual needs.

VIII. Suitability of Eclectic Therapy in Multicultural Settings

- Since techniques are chosen to match the client's needs, cultural influences and limitations are taken naturally into account.

IX. Key Eclectic Concepts and Terminology

- The technique is matched with the client's needs.
- Role models for psychotherapy should be broadened, i.e., not just therapist-client, but employer-employee, or master artist-artist, etc.
- Integration model: need step
 choice step
 action step
 image step.
- Reintegration model: counteraction
 catharsis
 proaction
 reintegration.

X. Techniques Specific to the Eclectic Therapy Model

- Eclectic counselors choose techniques that match their personalities, their skill levels, and the needs of the clients.
- **Technical eclecticism** represents the choosing of techniques from many different schools without subscribing to the theoretical position(s) of the school borrowed from.

XI. Criticisms of the Eclectic Therapy Model

- An eclectic approach requires a highly skilled and flexible counselor.
- Some counselors may confuse technical eclecticism with **theoretical eclecticism/integration** which represents the approach of developing a conceptual framework under which one synthesizes the best of theoretical approaches. Some in the field regard theoretical eclecticism as being a confusing, dangerous approach. Arnold Lazarus, for example, suggests that therapists remain theoretically consistent but technically eclectic (1997).

XII. Additional Information Related to the Eclectic Therapy Model

- A. Frederick Thorne**, the first editor of the *Journal of Clinical Psychology* in 1945, was the first “big name” associated with the term eclecticism. He viewed true eclecticism as being rigidly scientific and measurable, not just “a hodgepodge of facts.” He called his work with clients “psychological case handling,” not psychotherapy, as he felt the tenets of psychotherapy had not been scientifically validated.
- B. Arnold Lazarus’ Multimodal Therapy** (Lazarus, 1971) uses traditional methods and adds an assessment procedure. It deals in great depth and detail with sensory, imagery, cognitive, and interpersonal factors and their interactive effects. A basic premise is that the client is troubled by a multitude of specific problems that should be treated with a multitude of specific treatments. The obvious behavioral bent in Lazarus’ work comes from his close association with Joseph Wolpe.
- Assessment exam – BASIC ID is the format for answering the questions of what works, for whom, and under what circumstances. It takes into account the uniqueness of the client and the seven basic separate but intertwined areas of functioning:
 - B = Behavior (overt, measurable)
 - A = Affect (strong feelings, emotions, mood)
 - S = Sensation (the five senses)
 - I = Imagery (how one sees self)
 - C = Cognition (basis of values and beliefs)
 - I = Interpersonal relationships (interactions)
 - D = Drug/Biology (influences on body)
 - Lazarus asserts that each modality of the BASIC ID must be addressed, or the assessment and treatment plan is not complete.
 - Lazarus recommends brief and comprehensive therapy. Effective therapy can be practiced in a short timeframe if these **eight issues** are actively addressed (Lazarus, 1997):
 1. Ambivalent or conflicting feelings
 2. Maladaptive behaviors
 3. Misinformation
 4. Lack of information
 5. Interpersonal demands and pressures
 6. External pressures and demands (not from close interpersonal networks)
 7. Severe traumatic experience
 8. Biological dysfunctioning
 - The focus in multimodal counseling is to give the client a broad range of coping techniques, so the client can continue to apply these techniques from day to day.
 - The multimodal counselor is an “authentic chameleon,” according to Lazarus (1993), able to choose relationship styles and techniques that fit the situation. Flexibility and versatility are key to achieving technical eclecticism.

C. Gordon Allport

- Gordon Allport (Hunt, 1993) is both an eclectic and a trait theorist who insisted on studying personality through healthy, normal, mature adults.
- He took issue with Freud on the importance of the unconscious saying that healthy people function in rational and conscious terms, aware of and controlling many forces that motivate them.
- Neurotic or disturbed persons function more in the unconscious.
- People are more shaped by present and future events than by those of the past. Growth is discontinuous.

D. Communication Skills Approaches

The communication skills models employ training/education to treat common human problems. New knowledge and effective skills are the answers to malfunctions or deficits in psychological or interpersonal areas.

All of the communication skills approaches place great emphasis on Rogers' three core therapeutic conditions of empathy, genuineness, and unconditional positive regard.

1. Gerard Egan's Skilled Helper Approach

Egan (1998) has formulated a broad based, humanistic **problem-solving model** comprised of three stages. Egan considers taking action and evaluating results to be key to every step of every stage rather than being separate steps taken at the end of the process. Having an attitude of action and evaluation throughout the process acts as an early detection of what is going wrong, what is working, and when the helping process can be terminated successfully.

Stage 1: Initial problem clarification

Respect, genuineness, and what Egan calls primary-level accurate empathy are needed and evidenced. Egan's primary-level accurate empathy is communicating the understanding of the client's feelings and what is behind those feelings.

Step 1-A: The story – includes details to give a clear picture of what is going on.

Step 1-B: Blind spots – includes breaking through blind spots to help clients see themselves, their situations, and their opportunities clearly.

Step 1-C: Choosing the right problems/opportunities to work on – includes working on issues that will make a difference.

Stage 2: Setting goals based on dynamic understanding

Challenging skills, information sharing, what Egan calls advanced accurate empathy, confrontation, and self-disclosure by the counselor are required. Egan's advanced accurate empathy includes communicating the understanding of what the client is only partially expressing or implying.

Step 2-A: Possibilities for a better future – includes helping clients spell out the various elements of the desired future.

Step 2-B: The change agenda – includes choosing realistic and challenging goals.

Step 2-C: Commitment – includes finding the incentives that will encourage persistence.

Stage 3: Facilitating action

Program development (outlining the means to reach the goals), facilitating action (preparation, challenging, supporting), and evaluation are necessary components of this stage.

Step 3-A: Possible actions – including evaluating the many ways a goal can be achieved.

Step 3-B: Choosing best-fit strategies – includes choosing the strategies that best fit the client's temperament, style, talents, resources, etc.

Step 3-C: Crafting a plan – includes organizing the actions to be taken.

2. Robert Carkhuff's (1981) Human Resource Development Model

Carkhuff's levels of goals assume an ongoing process rather than reaching an end state. As such, the counselor will be striving for full development and will model the goal levels as part of the interaction with the client. A self-directed process, not imitation, is the desired result.

Level 1: Process goals

Exploration – Where is the client in relation to where he or she wants to be or needs to be?

Understanding – Where does the client want to be?
How shall the goal be defined?

Action – The client moves from where he or she is to where he or she wants to be.

Level 2: Intermediate goals

Skills result from achieving process goals:

- Physical skills such as exercise or functional habits.
- Interpersonal skills such as listening, initiating, etc.
- Cognitive skills such as analyzing, interpreting, etc.

Level 3: Ultimate goals

High levels of responsiveness and initiative lead to self-actualizing.

FEMINIST THERAPY (GENDER-FAIR)

I. Major Figures

Unlike other therapy models, no one person founded feminist therapy. Feminist therapy has evolved from the work and efforts of many individuals in many disciplines.

II. Overview of the Feminist Therapy Model

- Feminist therapy has its roots in the women's movement of the 1960's. A "sisterhood" of women arose to address the oppression of women and to advance the value of women's perceptions and values.
- Traditional therapy models were formulated by white, Western (European or American) males and tended to view mental health in terms of that background. Feminist psychology therefore attempts to address the constraints put on both men and women through psychological oppression and the sociopolitical status afforded to each. Identity development, goals, and self-concept are all viewed as products of socialization.
- The rise of the feminist viewpoint is credited with the current attention being given to issues of rape, incest, child abuse, domestic violence, and sexual harassment.

III. Goals of Feminist Therapy Treatment

- Feminist therapy seeks to transform both the individual and society (Corey, 2001).
 - Individual** – to empower the individual to break free from gender-role expectations; to reject societal expectations such as those of appearance, relationship to men, relationship to other women, etc.
 - Society** – to force replacement of gender-role expectations; to foster interdependence, cooperation, and mutual support for both women and men.
- Worell and Remer (1992) have listed these goals of feminist therapy:
 1. Gaining awareness of one's gender-role socialization process.
 2. Identifying internalized gender-role messages and replacing them.
 3. Understanding the negative impact on sexist, oppressive beliefs and practices in society.
 4. Acquiring skills to generate change in oneself and in society.
 5. Developing freely chosen behaviors.
 6. Trusting one's experiences and intuition.
 7. Appreciating female-related values.
 8. Assisting women in taking care of themselves.
 9. Helping women accept and like their bodies.
 10. Identify and respond to one's sexual needs rather than the sexual needs of someone else.

IV. Role of the Feminist Therapy Counselor

- The feminist counselor acts much like a humanistic or a person-centered therapist. The relationship with the client is a collaborative partnership.
- The counselor believes the client has the capacity to be constructive and to make positive decisions and changes.
- The counselor strives to empower the client to transcend societal role-stereotyping; to encourage the client to live by his or her internal values, rather than external (societal) values.
- Appropriate self-disclosure and education about the therapeutic process act to tear down walls and barriers of power and control.

V. Normal Development

- Differences between the behaviors of men and women are due to gender-role socialization.
- Since development takes place over the lifespan, changes in behavior and personality patterns can take place at any time.

VI. Development of Behavioral Disorders

- Accepting traditional roles hinders the true development of men and women. Gender stereotypes are so powerful that one must either acquiesce to the role for the sake of being socially acceptable or rebel and fall prey to the consequences.
- Adjusting to the status quo is not true personal development.

VII. Applications of the Feminist Therapy Model

- Both men and women can benefit from the emphasis on empowerment.
- Feminist therapy has been successfully used in a variety of settings: individual, groups, family, relationship counseling, community intervention, etc.
- Other therapy approaches can be enhanced with feminist principles and interventions.

VIII. Suitability of the Feminist Therapy Model in Multicultural Settings

- Suitable for:
 1. Clients willing to invest in significant personal change even if their current culture will oppose the change.
 2. Clients wanting/willing to be an active participant in social change.
 3. Clients wanting to break out of discriminatory and oppressive environments.
- Not suitable for:
 1. Clients who are not able to overcome the criticism and the isolation that their new behaviors, roles, and attitudes will bring.
 2. Cultures which reject self-determinism and individual empowerment.

IX. Key Feminist Therapy Concepts and Terminology

- Feminist therapy as a unified model is still evolving. As such, no specific definition can be given. There are, however, a number of distinguishing philosophical principles that guide the movement.
- Feminist counselors regard a feminist view as:
 1. Including both female-oriented and male-oriented constructs in evaluating human nature.
 2. Assuming that men and women would develop along similar paths if society was gender-free.
 3. Recognizing that different races, cultures, and nations will have differing influences on human development and interactions.
 4. Valuing same-sex relationships and not assuming heterosexual as the only normative and desirable orientation.
 5. Acknowledging behavior as resulting from the confluence of intrapsychic, interpersonal, and environmental influences.
 6. Asserting that present personality patterns and behavior can be changed at any point along the life-span continuum.
- In contrast, traditional therapy models are androcentric, gendercentric, ethnocentric, heterosexist, intrapsychic, and deterministic.
- Interrelated and overlapping principles form the basis of feminist psychology:
 1. **“Personal is political.”** Once individuals are free from gender role constrictions, they will model flexible, non-stereotyped behaviors that are attractive to others and that will positively influence the behaviors of men and women within work and social networks (Enns, 1993).
 2. The counselor and client collaborate in an **egalitarian relationship**. Since feminist therapy is rooted in opposing the powers and controls of society on one’s life, the counselor rejects the power (expert) position.
 3. **Women’s experiences are given credence and value in and of themselves**, not in comparison with men’s experiences.
 4. **“Mental illness”** and emotional pain or distress are redefined in terms of the female experience. Intrapsychic, interpersonal, and external factors must all be considered.
 5. **Women and men are equal**. Differences are the result of socialization.
 6. **All forms of oppression must be challenged**, not just oppression of women.
- Feminist therapy purports a gender-free, flexible, interactionist, and life-span-oriented framework (Corey, 2001).

X. Techniques Specific to the Feminist Therapy Model

- Any technique that promotes the recognition of gender-role socialization can be utilized.
- Gestalt therapy and cognitive behavioral therapies contain many techniques which are compatible with feminist therapy.
- Consciousness-raising techniques are often used along with techniques from traditional therapy models (Corey, 2001) including:

gender-role analysis and intervention	assertiveness training
power analysis and intervention	reframing and relabeling
bibliotherapy	cognitive restructuring
journal writing	identifying and challenging untested beliefs
therapist self-disclosure	role playing
psychodramatic methods	group work
self-disclosure	social action

XI. Criticisms of the Feminist Therapy Model

- Feminist therapy can direct an individual toward life values that the client does not believe in.
- In theory, feminist therapy is gender-fair, both pro-women and pro-men. The same therapeutic principles should be applicable to both men and women. Therapy can end up being anti-men, however, in actual practice.

XII. Additional Information Related to the Feminist Therapy Model

- **Karen Horney** (1967) was the first woman psychiatrist to raise questions about the fundamental assumptions concerning the psychoanalytic conception of women.
- **Phyllis Chesler's** groundbreaking book *Women and Madness* (1972) analyzed how patriarchy in society shapes our definition of mental illness.
- **The Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel** (1970) study on sex-role stereotypes and clinicians' judgments found that both male and female clinicians' attitudes toward healthy adult males and healthy adult, sex unspecified were the same. Their concepts of mature healthy adults differed significantly from their concept of healthy adult females.
- **Carol Gilligan's** (1982, 1992, 1996) studies supported her claim that the moral reasoning of males and females centers around different concerns and issues. Males tend toward a justice perspective, and females tend toward a care perspective.
- **Nancy Chodorow** (1978, 1989) proposed a revision of psychoanalytic theory which emphasized that women tend to define themselves in terms of their relationships with others. Girls are raised by their mothers and take on the mother's psychological characteristics which have been traditionally that of the nurturing caregiver.
- **Sandra Bem** (1981) formulated a gender schema theory that stated that boys and girls learn the masculine and feminine roles that are expected of them through observing society and applying these learned perceptual sets to themselves.
- **Jean Baker Miller** (Miller & Stiver, 1997) has proposed a self-in-relation model of women's development that ties a woman's sense of self to her connections with others. Miller has expanded her theoretical application to other cultures and is tackling diversity, social action, and workplace issues.
- **Carolyn Enns** (1993) conducted an extensive summary and history of the twenty years since feminine therapy began. Since she is quoted extensively in works regarding feminist theory and therapy, her conclusions are noteworthy:
 1. It remains difficult to define feminist therapy and its many variations. Psychologists cannot assume the label of a feminist therapist by merely "adding feminism and then mixing."
 2. Although biases have been revealed and removed from psychological theories and practices during the past twenty years, psychological interventions, personality theories, and diagnostic practices are still influenced by political and social power structures.
 3. Concepts that appear to be most feminist or antifeminist on initial examination may merit further examination.
 4. Feminist therapists must recognize the diversity of women and men that is conveyed by their various problems, racial or ethnic identifications, economic status, personality styles, and exposure to "isms" such as racism, ageism, sexism, and heterosexism.
 5. Feminist therapists, researchers, and teachers must continue to work toward integrating social and individual change efforts.

- **The Association for Women in Psychology (AWP)** began in 1969 at a meeting of the American Psychological Association (APA) because the AWP felt the APA was ignoring the issues being raised by the women's movement. Within the organization, feminist therapy was first named as an entity in 1972 (Enns, 1993). This non-profit scientific and educational feminist organization “seeks to act responsibly and sensitively with regard to women by challenging the unquestioned assumptions, research traditions, theoretical commitments, clinical and professional practices, and institutional and societal structures that limit the understanding, treatment, professional attainment and responsible self determination of women and men, or that contribute to unwelcome divisions between women based upon race, ethnicity, age, social class, sexual orientation or religious affiliation” (www.awpsych.org).

The APA developed its own division for the psychology of women in 1973 due to the efforts of the Association for Women in Psychology. Division 35 provides “an organizational base for all feminists, women and men of all national origins, who are interested in teaching, research, or practice in the psychology of women.”

- **The National Council for Research on Women** was founded in 1981 as a working alliance with ninety-one women's research and policy centers, with more than 3,000 affiliates and a network of over 200 international centers. Their purpose is to “enhance the connections among research, policy analysis, advocacy, and innovative programming on behalf of women and girls” (www.ncrw.org).
- **Laura Brown** was instrumental in founding the Feminist Therapy Institute in 1983, an organization created to provide an organizational home for advanced feminist therapists so members can effectively contribute to the increasing body of knowledge and practice known as feminist therapy and seeks to enrich this theory and advance standards of practice. Brown has particularly contributed to the current thinking on ethics and boundaries in light of feminist theory, as well as the treatment of trauma survivors.

NEURO-LINGUISTIC PROGRAMMING (NLP)

I. Major Figures

Richard Bandler

John Grinder

II. Overview of the NLP Model

- **Richard Bandler and John Grinder** (Bandler & Grinder, 1979) based their theory on linguistics and theories of personalities. The term *programming* was chosen to infer an organization and system of ideas similar to early computer programming.
- **Bandler and Grinder** observed expert counselors (most notably Virginia Satir, Milton H. Erickson, and Fritz Perls) in their sessions with clients and compared what was done with what the counselors said they had done. Subtle changes in breathing, skin tone, eye movements, etc. were noted.
- NLP is concerned with how the processes of the brain perceive, store, and recall events.

III. Goals of NLP Treatment

- The goal of therapy is to discover the client's method of perception, storage, and retrieval through observing the eye movements and listening to the client's language.
- Once this pattern is understood, the therapist teaches the client ways to consider the problem area using the same representational system pattern, or perhaps by using another pattern that has not been used before.
- Example: A client uses mostly visual perception and not kinesthetics. The therapist may ask the client to visualize himself/herself doing a new behavior, and then have him/her look down and to the right to see how he/she "feels" about that behavior.

IV. Role of the NLP Counselor

- The therapist is a communicator/educator.
- Not a lot of time is spent on the therapist/client relationship as compared to other forms of therapy, though this is still considered important.
- Rapport is more quickly established through observing the client's pattern and other non-verbal cues and then "mirroring" these back to the client thereby "telling" the client behaviorally that the therapist understands him/her.

V. Normal Development

Normal development is strictly a matter of determining if a behavior pattern works or not. If a person has successfully modeled *appropriate* behavior, then development will be judged successful.

Successful modeling of appropriate behavior requires three points of knowledge:

- A. The behavior and physiology the model uses to perform the skill
- B. The model's thinking strategies in performing the skill
- C. The beliefs and values of why the model performs the skill

If any of these components is missing, the new skill cannot be acquired by the client.

Additionally, taking a skill out of context changes the skill. For example, modeling the thinking processes of Albert Einstein will not automatically produce another Einstein.

VI. Development of Behavioral Disorders

NLP does not address Behavioral Disorders as such. Instead, a behavior “works” or “doesn’t work” for the client.

VII. Applications of the NLP Model

This approach has been very popular in business circles, particularly with sales people and with those interacting with foreign cultures.

VIII. Suitability of the NLP Model in Multicultural Settings

Cultural patterns lend themselves readily to modeling thereby allowing an NLP practitioner to discover the representational systems employed by a culture. These discoveries can be translated into an understanding of cultural courtesies, customs, etc.

IX. Key NLP Concepts and Terminology

- Each person has a unique method of using his/her sensory systems to experience the world, using one major sense predominantly, be it visual, auditory, or kinesthetic.

X. Techniques Specific to the NLP Model

1. **Mirroring to establish rapport** – The therapist asks "how" questions and observes eye movements to determine the representational system:
 - a. Eyes up and to the right or up and to the left both indicate visual perception.
 - b. Eyes to the left center or left downward indicate inner auditory selection.
 - c. Eyes to the right lower corner indicate kinesthetic or feeling perception.
 - d. Eyes to the right central indicate auditory output, or what the client may be rehearsing to say.
2. **Pacing and leading** – The therapist paces or matches a non-verbal behavior in the same rhythm as the client and then changes to another behavior or speed to lead the client to a new behavior. (Example: A client with a rapid breathing pattern can be paced by the therapist's moving a finger in sync with the breathing. Once this is done, the therapist can slow the finger pace, and the client's breathing will follow the new rhythm.)
3. **Anchoring** – The client does an internal search for a representation of the problem to be solved. Once experienced, the client is "anchored" to a touch, a word, or a color representing that these cues are the old issue. Then a new possibility is created or an old solution with modifications is considered. When the **new anchor** is activated, the mind connects/applies the new solution to the problem. This is similar to classical conditioning or the concept of a posthypnotic suggestion.
4. **Reframing** – The counselor helps the client assign a new perception to a given situation, to see it in a new light.
5. Metaphors and story telling are frequently used and are useful as a short-term therapy model.

XI. Criticisms of the NLP Model

- Research validating the approach is lacking.
- Claims to cure long-standing phobias in less than an hour are hard to believe.
- NLP techniques are easily reduced to simple manipulation depending on the value and belief system of the practitioner.
- Step by step models of techniques imply sequential order and brains that are all alike. Reality demonstrates that steps of progress are sometimes concurrent and no two people have the same brain structure and experience history.

XII. Additional Information Related to the NLP Model

Early NLP literature relied heavily on simple computer analogies to explain the brain's workings. Since technology and artificial intelligence have advanced greatly since that time and have become more accessible to more people, the original analogies and wording are not as applicable. Efforts are underway, therefore, to base the 'programming' part of NLP on neural network models which take advances in biology and cognitive science into account.

ADDITIONAL MISCELLANEOUS INFORMATION

1. **Androcentric** – conclusions regarding human development are based on male-oriented constructs.
2. **Baseline** – a starting or reference point, figure, amount, level, etc. with which others can be measured or compared. In behavior therapy, the baseline is the frequency of behavior before or without conditioning.
3. **Birth order** – Adler stressed the importance of birth order in development. In contrast, the best selling book of the 1970's was *Your Erroneous Zones* in which Wayne Dyer criticized this concept.
4. **Co-Morbidity** – refers to a problem or problems that pre-date or occur separately from another problem or problems. While a cause-effect relationship may not exist, a correlation may exist between the problems. For example learning disabilities are often confused with Attention Deficit Hyperactivity Disorder (ADHD), though these are two distinct conditions. ADHD is not in and of itself a specific learning disability. However, a very large percentage (about 60 to 80%) of those who have ADHD also have a learning disability. It can therefore be said that there is a significant level of co-morbidity between learning disabilities and ADHD (Biederman, et al., 1992).
5. **Consciousness raising** – a technique borrowed from the Women's Liberation Movement; a mechanism by which women could comprehend the sociopolitical structure of gender by analyzing their personal lives.
6. **Covert** – behavior that is not seen or observable (a thought or visualization).
7. **Deterministic** – assumes personality patterns and behavior are biologically fixed progressions.
8. **Ethnocentric** – assumes that what is true of human development and interactions in one culture is true in all other cultures and with all other races.
9. **Gendercentric** – assumes that women and men develop naturally along two different paths.
10. **Heterosexist** – assumes a heterosexual orientation to be normative and desired. Same-sex relationships are devalued.
11. **Holistic** – emphasizing the whole person.
12. **Hull, Clark** – Clark Hull's fame stems from his development of a conceptually tight and mathematically-oriented theory of motivational process (drive). It was considered a masterpiece of theory construction when it was published. (See more in Behavioral Theories in Normal Human Growth and Development.)
13. **Insight** – concept actually originated by the gestalt psychologist Wolfgang Kohler as he observed chimpanzees and the great apes in the Canary Islands solving problems through trial and error, i.e. discovering that putting two sticks together would reach the food dish. He called this discovery or realization "insight experience." His book *The Mentality of Apes* (1925) applied the concept of insight to therapy. Some learning theorists will therefore classify learning in three ways: association (classical conditioning), reinforcement (operant conditioning), and insight.
14. **Intrapsychic** – assumed to arise or take place in the mind.
15. **In vivo** – in biology in vivo means in a living organism; in psychology, the term refers to treatment of an overt behavior.

16. **Johari's Window** – The Johari Window (from the first names of its inventors, Joseph Luft and Harry Ingham) (Luft, 1969) is a four-paned “window” that serves as a model for human interaction and communication:
- a. The “open” window represents those things that one knows about oneself and that other people know. Examples include factual information such as one’s name as well as feelings, wants, needs, etc., that are openly expressed.
 - b. The “blind” window represents those things that others know about oneself but that one may be unaware of. For example, a person may be unaware of a bug on their shoulder or that their tie is crooked while it is obvious to others. These blind spots also include personality and interactional traits.
 - c. The “hidden” window represents those things known about oneself but hidden from others. These are sometimes referred to as “hidden agendas” or as issues “under the table.”
 - d. The “unknown” window represents those things of oneself that are not known by oneself or others.

The Johari Window demonstrates the different kinds of information we deal with when we interact with others. The underlying assumption is that moving information to the “open” window facilitates deeper relationships and clearer communication. For further information and several illustrations, go to the following website: http://www.noogenesis.com/game_theory/johari/johari_window.html

17. **Overt** – behavior that can be seen or observed.
18. **Phenomenologic** – the therapist must be able to view the client’s world as the client sees it. This term began as strictly a Rogerian term, but now all models apply it.
19. **Paradigm** – a model. For example, a counselor following a non-directive paradigm would allow the client to lead the way in exploring thoughts and feelings. The counselor would give a minimum of direction. Carl Rogers’ Client or Person-Centered Therapy is non-directive. A directive or active therapy paradigm would have the counselor actively giving the client direct suggestions about how to behave, feel, or think.
20. **Pica** – the tendency to eat items other than food, e.g. chalk, clay, bits of trash, etc. Often leads to mental retardation.
21. **Reich, Wilhelm** – a theorist who believed that repeated sexual gratification is necessary to cure emotional illness. His orgone box therapy was supposed to increase orgone life energy. The FDA took the box off the market and Reich was incarcerated where he died. His theory is still debated.
22. **Subliminal** – involving or using stimuli intended to take effect subconsciously by repetition. The American Psychological Association (APA) does not accept subliminal stimuli as effective. Wilson Bryan Key believes, however, that subliminal stimuli are effective and has written books such as *Subliminal Seduction* and *Media Sexploitation* to explain this theory. Note: Subliminal stimuli should not be confused with sublimation (ego defense mechanism).
23. **Symptom substitution** – the hypothesis that if only the superficial behavioral manifestations of a neurosis are treated in psychotherapy the unresolved underlying conflict will ‘erupt’ elsewhere, and new (and potentially more serious) symptoms will emerge. Some eating disorder treatments are based on this theory. Psychoanalytical therapists believe in symptom substitution. Behavioral therapists, who deal only with maladaptive behavior and not the underlying cause, do not believe in symptom substitution.
24. **Yin and Yang** – in Chinese Taoist philosophy the yin is the passive, negative, feminine force or principle in the universe, both contrasted with and complementary to the yang, the active, positive, masculine force or principle in the universe.

A ^D_D**J** is **FRESH**

Adler

Dreikers

Dinkmeyer

Jung

is

Fromm

Rank

Erikson

Sullivan

Horney

CLASSICAL CONDITIONING

Let's say we have a man who makes his living as a carpenter (or at least he tries) to make a living at it. Because he's afraid of insects, spiders in particular, he has a panic attack every time he turns over a board and there's a spider on it. He has to leave the job for the day, which makes it hard to keep a job. He comes to you and wants your help. You decide to use SYSTEMATIC DESENSITIZATION. Systematic desensitization uses counter-conditioning or a counter-condition to the anxiety-provoking stimuli. In this case, the spiders provoke anxiety and a good counter-condition would be relaxation training. So before you begin to set goals, you've got to teach him how to relax – that's the counter-condition to the anxiety provoking stimuli. You decide to refer him out to a friend, Dr. Simpson, who specializes in relaxation training and he learns to relax on cue!

With the counter-condition in place, you now begin goal setting. You ask, "What would you do if you were not afraid of insects?" He replies, "That's easy – I would keep a job!" That becomes the major goal — Work an 8-hour day without a panic attack. The next step is to work out a hierarchy of goals, working in reverse, down to some first or initial step. Remember that this could possibly take 2 or 3 sessions because the client has to have input, discuss, and completely agree if treatment is to be successful. Then you start working the steps and each time he comes to session you ask, "DID YOU DO THE HOMEWORK?" "HOW DID YOU DO IT?" "DID YOU FEEL ANY ANXIETY?" Somewhere in the process he'll begin to feel anxious.....let's say at step #5: "What did you do?" He replies, "I started to relax, just like Dr. Simpson taught me!" "Did it work?" He responds with, "It worked like a charm – I calmed myself right down!"

At about step #10 you might have a video about insects and you ask about his level of anxiety, etc. He goes right into his relaxation mode and calms down.

At about step #13 you ask him to imagine himself at work, turning over a board and finding a nest of daddy long-legs (i.e. Implosive Therapy).

Then, at step #18 you stop by a pet store and pick up several non-poisonous tarantulas and have them in your office by your chair. While you are talking, you reach down, flip the lid off, and throw those tarantulas on his lap which brings on a panic attack (i.e. Flooding — You flooded your client with the anxiety producing stimuli). He jumps out of the chair and has a panic attack — hollering and hyperventilating, but you calmly ask, "What are you supposed to be doing?" He catches himself, begins relaxing, and calms down. Perhaps he even helps you find the tarantulas and helps you put them in the container again.

The entire process of going from Step #1 to Step #20 is called SHAPING his behavior. Each time he successfully completed a step is called SUCCESSIVE APPROXIMATION. Step #20 was successful when he could work 8 hours a day, encountering all types of insects and not have a panic attack. His behavior was shaped by Systematic Desensitization using CLASSICAL CONDITIONING.

OPERANT CONDITIONING

Suppose your client is a lady who is afraid of flying. You ask, “So where would you go if you weren’t afraid of flying?” She replies, “I’d go visit my sister in Wyoming! Now I have to drive or take a bus, but I’d really like to be able to fly!” After discussion, this becomes your client's major goal.

Using Operant Conditioning you would sit down with her and come up with a schedule of reinforcements such as buying new clothes and luggage for her flight. You would work out a list of goals with her and a corresponding schedule of reinforcements/rewards. Therefore, when she completes Step #1, she would know what her reward is. LIKEWISE you would have to work out a list of agreed upon punishments. Again, this could take 2 or 3 sessions (or more because the client has to "sign-off" on each). In her schedule of reinforcement, since she likes to buy clothes, you and she might agree that each time she meets her goal, she would get to buy something for her travel wardrobe or one piece of new luggage at a time.

Step #1 of her treatment plan may be to “Go buy a magazine with pictures of airplanes in it.” Next week she would bring in the magazine and you would ask, “How’d it go? Did buying the magazine create any anxiety for you?” “NO.” “Did you look through it?” “YES.” “Did that cause you any anxiety?” “NO.” “OK – **Your homework for next week** is to cut the magazine up and make a collage of the pictures and place yourself somewhere in that collage.” HAVING ACCOMPLISHED STEP #1, she gets her **reward** — she gets to go buy her first piece of luggage.

The following week she returns with the completed collage and she gets to go buy her 2nd piece of luggage – that’s the reinforcement. However, let's say we get to Step 7 or 8 and she reaches a place where she just could not accomplish that goal; perhaps she could not bring herself to walk through the airport terminal and go up to the ticket counter as if she was going to buy a ticket. **THE agreed to PUNISHMENT takes place: SHE HAS TO RETURN ALL OF THE LUGGAGE AND BRING YOU THE CREDIT SLIP.**

However, when she gets past this step SHE GETS TO REWARD HERSELF by going back and buying back all of the luggage at one time.

Using **IMPLOSIVE THERAPY** you might have her come in and watch a video taken from the cockpit of a plane. Then you would have her imagine the sights and sounds of flying.

Using **FLOODING** you take her out to the airport and get her in a plane, in a seat and strap her in. If you know the pilot, perhaps they would crank the engine and rev it a little to give her the sensation of the noise and the plane vibrating.

The last step (i.e. the main goal) would be seeing her off at the airport on the way to Wyoming with all her new luggage filled with new clothes.

Overall, we were **SHAPING** her behavior by **SUCCESSIVE APPROXIMATION** using Operant Conditioning.

Rational Emotive Therapy's A-B-C- THEORY OF EMOTIONAL DISTURBANCE

It is not the event, but rather it is our interpretation of it, that causes our emotional reaction.

A = ACTIVATING experience. (A womanfriend breaks the news that she is going out with another man, and therefore wishes to break off the relationship with you.)

B = BELIEF about (or the interpretation) of the experience.

“I really must be a worthless person.”

“I’ll never find another great woman like her.”

“She doesn’t want me; therefore no one could possibly want me.”

“This is awful!”

“Everything happens to me!”

“That bitch! She shouldn’t be that way.”

“I can’t stand the world being so unfair and lousy.”

C = upsetting emotional **CONSEQUENCES**

Depression and/or hostility

D = DISPUTING of irrational ideas

“Where’s the evidence that because this woman wishes to end our relationship that I am a worthless person; or that I’ll never be able to have a really good relationship with someone else; or even that I couldn’t be happy alone?” and/or “Why is it awful that I’m not getting what I want?”/“Why shouldn’t the world be full of injustices?”

E = new **EMOTIONAL** consequence or **EFFECT**

Sadness: “Well, we did have a nice relationship, and I’m sorry to see it end – but it did have its problems and now I can go out and find a new friend.”

or

Annoyance: “It’s annoying that she was seeing someone but it isn’t awful or intolerable.”

Chapter 6

Family Therapy

FAMILY THERAPY

NCE – Chapter 6

Chapter Outline

INTRODUCTION TO FAMILY THERAPY

- I. History and Evolution
- II. Systems Paradigm
- III. Couples
- IV. Families

For each of the models below, information is arranged under these headings:

- I. Important Figures
- II. Overview
- III. Goals of Treatment
- IV. Role of the Counselor
- V. Role of the Symptom
- VI. Normal Family Development
- VII. Development of Behavioral Disorders
- VIII. Key Concepts and Terminology
- IX. Techniques

The Models covered in this chapter are:

- Psychodynamic Family Therapy
- Satir's Experiential Family Therapy
- Whitaker's Experiential Family Therapy
- Structural Family Therapy
- Strategic Family Therapy
- Bowen Family Systems Therapy
- Milan Systemic Family Therapy
- Cognitive Behavioral Family Therapy
- Brief Solution Focused Family Therapy
- Narrative Family Therapy
- Integrative Models
- Communications Model

MISCELLANEOUS INFORMATION

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FAMILY THERAPY

NCE - Chapter 6

INTRODUCTION TO FAMILY THERAPY

I. History and Evolution

Becvar and Becvar (1996) give an outline of the history and evolution of the field of Family Therapy by decade beginning with the 1940s.

A. In the 1940s

1. The family therapy movement was begun by a group of researchers and theorists from various disciplines.
2. A paradigm shift occurred based on the cybernetics model that placed emphasis on organization, pattern, and process rather than matter and content.
3. Key figure – Gregory Bateson

B. In the 1950s

1. Through research on schizophrenia, family treatment was initially legitimized.
2. A large number of pioneers discovered family therapy.
3. There was a shift in emphasis from isolation to community, cooperation, and shared creation.
4. Key figures:

Nathan Ackerman	Murray Bowen
Carl Whitaker	Theodore Lidz
Lyman Wynne	Ivan Boszormenyi-Nagy
John Elderkin Bell	Christian Midelfort

C. In the 1960s

1. There was a paradigm shift to a systemic framework. Activities occurred such as expanding knowledge of family therapy, delineating concepts, and enlarging the repertoire of techniques related to family therapy.
2. This was a time of expansion in family therapy. There was increasing recognition of the model at professional meetings, a continuation of research, initiation of new research, and increasing publication of books and articles related to the modality.
3. Key figures:

Don Jackson	Jules Riskin
Virginia Satir	Richard Fisch
Jay Haley	Paul Watzlawick
John Weakland	Salvador Minuchin

D. In the 1970s

1. New approaches of family therapy developed into schools and theoretical models.
2. Publications by the founders reached a peak.
3. Large numbers of students went to various training centers to learn from masters.
4. The boundaries of the major approaches were more clearly delineated.
5. Key figures – (the Milan associates):

Mara Selvini Palazzoli
Gianfranco Cecchin

Luigi Boscol
Guiliana Prata

E. In the 1980s

1. This was a period of integration. Family therapists knew and were able to utilize aspects of each of the models of family therapy.
2. The field was becoming increasingly aware of how some outside the systemic frame of reference had impacted family therapy.

F. In the 1990s

1. This was a period of challenge and innovation as the field maintained its self-critique and integrated various models.
2. Family therapists were feeling comfortable and somewhat complacent; there was increased criticism regarding lack of attention to gender related issues.

II. Systems Paradigm

Walsh (2002) articulates common tenets of systemic models of family therapy:

- A. **Nonsummativity** – The whole is greater than the sum of its parts. Components of a system can be understood only within the context of the whole system.
- B. **Boundaries** define the borders that separate a family system from other systems. This makes the family a distinct entity.
- C. **Circular causality** replaces linear cause and effect.
- D. A change in one part of a system affects all other parts of the system.
- E. Systems tend to be self-regulating. They seek **homeostasis** or **equilibrium**.
- F. When a family system is out of balance, feedback mechanisms attempt to bring the family back into equilibrium. **Feedback** is when a portion of a system's output returns to or is fed back into the system.
- G. The methods used to restore equilibrium can become problems themselves.
- H. The quantity and direction of energy in a system have an impact on the organization and functioning of that system. **Entropy** (the tendency toward disorder) and **negentropy** (openness to change and reorganization) both act on systems.
- I. A family systems perspective focuses on relationships within the entire family system rather than focusing on one individual in the family.
- J. **Equifinality** is the concept that there are multiple causes for any behavior or event and multiple effects flowing from any behavior or event. This is one of the fundamental concepts of the systems perspective.

III. Couples

A. Exclusion of All but the Marital Dyad

Counseling of couples necessitates exclusion of other significant family members. Although it is important to work with the entire system, there are times when it may be most appropriate to work solely with the marital dyad:

1. Addressing problems directly related to the marital relationship
2. Attempting to clearly mark the boundaries around the parental subsystem
3. Respecting the couple's privacy

B. Characteristics of a Healthy Couple (Becvar & Becvar, 1996)

1. Attitudes and beliefs
 - a. Belief in multiple realities; therefore, every perception is equally valid.
 - b. Perceptions are fallible; therefore, differences can promote growth rather than struggle.
 - c. People are basically neutral or benign. The motives of one's partner are usually decent.
 - d. Human encounters are typically rewarding.
 - e. Partners have a systemic perspective:
 - An individual needs to be part of a group in order to have definition, coherence, and satisfaction.
 - Causes and effects are interchangeable.
 - Behavior is a result of many variables rather than a single cause.
 - Humans are limited and finite and therefore cannot meet the many needed satisfactions to be found in relationships.
2. Behavioral patterns
 - Overt power difference is minimal.
 - There are clear boundaries.
 - The couple operates primarily in the present.
 - There is a respect for individual choice.
 - Skill in negotiating is apparent.
 - Positive feelings are shared.

IV. Families

A. Characteristics of a Healthy Family as Listed by Becvar and Becvar (1996):

1. A legitimate source of authority established and supported overtime
2. A stable rule system established and consistently acted upon
3. Stable and consistent sharing of nurturing behavior
4. Effective and stable childrearing and marriage-maintenance practices
5. A set of goals toward which the family and each individual works
6. Sufficient flexibility and adaptability to accommodate normal development challenges as well as unexpected crises (p. 124)

B. Life Cycle Stages

Life cycle stages refer to the predictable marker events or phases through which a family progresses. They may occur due to a change in family composition or a major shift in autonomy. The stages as listed by Goldenberg and Goldenberg (2000) are as follows:

1. Early stages: Forming and nesting
 - **Coupling** is when the family begins by establishing a common household with two people.
Task: Shift from individual independence to couple interdependence.
 - **Becoming three** is the stage initiated by the arrival of the first child.
Task: Interdependence to incorporation of dependence.
2. Middle stages: Family separation process
 - **Entrances** is a stage signaled by the exit of the first child from the family to the larger world.
Task: Dependence to partial independence.
 - **Expansion** is a phase marked by the entrance of the last child into the larger world.
Task: Support of continuing separations.
 - **Exits** refers to the first complete exit of a dependent member of the family. It is achieved by establishment of an independent household.
Task: Partial separations to first complete independence.
3. Last stages: Finishing
 - **Becoming smaller/extended** is the exit of the last child from the family.
Task: Continuing expansion of independence.
 - **Endings** are the final years that begin with the death of one spouse and continue to the death of the other partner.
Task: Facilitation of family mourning. Working through final separations.

C. Gender Issues

1. Traditional gender roles in the family system have been under scrutiny in recent times. These roles are modeled and taught from an early age by family and society at large.
2. There has been an increase in the awareness of gender's influence on family interaction. This awareness has led to recognition of the need to overcome gender stereotypes and co-create new interactive patterns. Although roles are still typically unequal in terms of work distribution, the pattern of gender-linked behaviors, expectations, and attitudes regarding gender roles is changing.

PSYCHODYNAMIC FAMILY THERAPY

I. Important Figures

- | | | |
|-----------------------|-----------------|---------------|
| A. Important Figures: | David Scharff | Jill Scharff |
| B. Secondary Figures: | Nathan Ackerman | James Framo |
| | Robin Skynner | Melanie Klein |
| | Samuel Slipp | |

II. Overview – Psychodynamic

- A. Is an integration of:
- psychoanalytic theory
 - object relations theory
 - family therapy
- B. Use of the following while working toward understanding and growth:
- principles of listening
 - responding to the unconscious
 - interpreting
 - developing insight
 - working with the transference and countertransference

According to this model, the family is perceived as a system comprised of sets of relationships that function in ways unique to that family system.

III. Goals of Treatment – Psychodynamic

- A. Therapists seek to understand the development of the individual personality in the context of early parent-child relationships.
- B. They also “expand the family’s capacity to perform the holding functions for its members and their capacities to offer holding to each other.” (Becvar and Becvar, 1996, p. 170)
- C. Aid family in expressing true understanding and compassion.

IV. Role of the Counselor – Psychodynamic

The therapist is to provide a nurturing safe environment in which unconscious object relations that are interfering with current relationships may be understood and resolved.

V. Role of the Symptom – Psychodynamic

The symptom serves the purpose of aiding the therapist in identification of the ego identity and the factors involved in its evolution. The focus shifts **from** the symptom **to** the relationship to the objects.

VI. Normal Family Development – Psychodynamic

A. The processes of introjection and identification determine:

- the personality
- organization of mental processes
- the manner in which individuals relate to each other

B. The key issues in development include:

1. Internalization and externalization of relationships
2. Attachment and separation
3. Introjection and projection
4. Transmuting internalization

VII. Development of Behavioral Disorders

Behavioral disorders develop when children mistakenly attribute the qualities of one person to another person resulting in distorted perceptions.

VIII. Key Concepts and Terminology

- A. **Object relations theory** is the combination of the study of individuals and their basic motives (psychoanalysis) and the study of social relationships (family therapy). “One looks for the dynamic and personal historical reasons for problems in current relationships” (Becvar & Becvar, 1996).
- B. **Splitting** refers to children separating their internal world into good and bad aspects. This is an evolving process consistent with their developmental stage.
- C. Four phases of development in object relations:
 - 1. **Differentiation** occurs when children develop to the point that they can explore aspects of mother and others.
 - 2. **Practicing** is the stage in which children explore the world.
 - 3. **Rapprochement** occurs as children have an increased awareness of their vulnerability and separateness. They repeatedly return to mother for reassurance.
 - 4. **Object relations constancy** is achieved as the child realizes his/her separation but relatedness to his/her parents.
- D. **Transference** refers to elements of an individual’s earlier experience and suggests that a person is being related to based on an amended version of the other person involved.
- E. **Countertransference** is the reciprocal interaction of the other person in the face of transference.
- F. **Internal objects** are mental images of the self and others built from experience and expectation.
- G. **Internalization**
 - 1. **Introjection** refers to “the child reproducing and fixating his/her interactions with the environment by organizing memory traces that include images of the object, the self interacting with the object, and the associated affect (can be good or bad)” (Nichols and Schwartz, 2001, p. 204).
 - 2. **Identification** involves the internalization of a role. The child takes on certain roles and behaves as his/her parents did.
 - 3. **Ego identity** is a synthesis of identifications and introjections. It provides a sense of coherence and continuity.
- H. **Holding environment** emphasizes the need for closeness yet separateness in order to achieve whole object relations.
- I. **Transitional objects** are neither self nor object yet are treated as if they were the beloved parent and the self.

IX. Techniques – Psychodynamic

- A. **Recognition and reworking** of the defensive projective identifications that have been required in the family
- B. **Provide contextual holding** for family members so that their attachment needs and conditions for growth may be achieved
- C. **Reinstatement or construction** of the necessary holding relationships between each of its members to support their needs for attachment, individuation, and growth
- D. **Return of family to overall developmental level** appropriate to its tasks as determined by its own preferences and by the needs of the family members
- E. **Clarification of individual needs** so they can be met with as much support as is needed from the family

SATIR'S EXPERIENTIAL FAMILY THERAPY

(also referred to as Communication/Validation Family Therapy)

I. Important Figure

Virginia Satir

II. Overview – Satir's Experiential

- A. The basic philosophy underlying the model begins with the belief that humans have an innate growth tendency in terms of body, mind, and feelings.
- B. Systems (both human and greater systems) are viewed as holistic systems and are viewed as continually interacting via communication to form a dynamic whole.
- C. The basic components in these systems are:
 - rules influence roles which have an impact on the effectiveness of functioning
 - an awareness of experience in the here and now allows for growth to occur in individual, family, and larger societal systems
- D. The focus of therapy lies on enhancing self-esteem and addressing interpersonal communication.

III. Goals of Treatment – Satir's Experiential

- A. The general goal is to facilitate growth in the family and between its members in terms of self-esteem and effective communication.
- B. Other goals:
 - Instill hope and encouragement in family members
 - Access, enhance, and create coping skills
 - Facilitate growth-oriented movement in the family beyond simple symptom relief by releasing and directing energy that was previously tied up in symptomatic behaviors

IV. Role of the Counselor – Satir's Experiential

- A. To create a comfortable, safe environment in order to encourage the ability of families to examine their behavior
- B. To reframe negative emotions such as anger as pain and encourage expression of feeling in therapy
- C. To educate clients in their roles of self-control and accountability
- D. To address noncongruent communication regarding content and process messages
- E. To model congruent communication

V. Role of the Symptom – Satir's Experiential

- A. Symptoms are framed within a relational perspective.
- B. Symptoms signal blockages in growth.
- C. The balance of the system is maintained through this blockage and has a survival connection to the system.

VI. Normal Family Development

- A. Functional families fulfill seven functions through
 - 1. Clear communication in the family system
 - 2. Effective roles
 - 3. Implementation of family roles that are:
 - few in number
 - reasonable
 - relevant
 - flexible
 - consistently applied
- B. The 7 mutually reinforcing functions:
 - 1. To provide a sexual experience for the mates
 - 2. To contribute to the continuity of the race by producing and nurturing children
 - 3. To cooperate economically by dividing labor between adults according to gender, convenience, and precedents and between adults and children according to the child's age and gender
 - 4. To maintain a boundary (by the incest taboo) between the generations so that smooth task-functioning and stable relationships can be maintained
 - 5. To transmit culture to the children by parental teaching
 - 6. To recognize when one of the members is no longer a child but has become an adult capable of performing adult roles and functions
 - 7. To provide for the eventual care of parents by their children

VII. Development of Behavioral Disorders

- A. The family is a closed system with poor interchange of information and resources within and without the system. Such interchange is maladaptive and rigid.
- B. The presence of dysfunction in one member is symptomatic of dysfunction in one of the larger systems (usually the family).
- C. Coping is viewed as the problem rather than the presence of stress or difficulty.
- D. Rules are fixed, arbitrary, and inconsistently applied.
- E. These rules maintain the status quo and are geared toward maintaining the self-esteem of the parents.
- F. The end result is chaos of the family.

VIII. Key Concepts and Terminology

- A. **Self esteem** refers to the value persons place on themselves. This is regulated by mutual appreciation and depreciation.
- **Individual self esteem** depends on one's level of autonomy from external validation
 - **Family self esteem** is the value placed on the family by its members
- B. **Communication** is the manner in which we send and receive information. It is the primary influence on relationships. Communication and self worth are viewed as the foundation of the family system.
- **Congruent communication** is direct, clear communication at the verbal and nonverbal levels. Feelings and experience are matched by words.
 - **Noncongruent communication** involves distorted, incomplete messages. It is ambiguous and typically involves double binds.
- C. **Roles** of family members
- **Blamer** – this individual accuses others and controls
 - **Placater** – goes along with others, pleases, avoids conflict
 - **Super reasonable** – over analytical and little emotion
 - **Irrelevant** – distracts others and cannot focus
 - **Congruent** – engages in honest, open communication of both thoughts and feelings
- D. **Rules of the family** are typically unspoken and influenced by the family roles.
- **Rigid rules** are associated with dysfunction. There is little possible change in the rules regardless of circumstances or family development.
 - **Flexible rules** are present in families with congruent communication.
- E. **Human mandala**
1. Self is the core of the "human mandala"
 2. Individual growth occurs through eight aspects of the mandala:
 - physical body
 - intellect
 - emotions
 - the five senses
 - social needs
 - nutritional needs
 - life space needs
 - spiritual needs

IX. Techniques – Satir's Experiential

- A. **Family sculpting** is a psychodrama technique in which a family member enacts a feeling or family structure. The goal is to offer a symbolic representation of family dynamics.
- B. **Family life fact chronology** is a history collected by the therapist. It traces the family time line and offers them an accepting environment in which to share relationship patterns.
- C. **Family reconstruction** is the rebuilding of the family through the reenactment of certain aspects of family history. The information for this reconstruction is typically taken from the family chronology.
- D. **Reframing** is reinterpretation of problems in order to shift the perspective of the client system.
- E. **Verbalizing presuppositions** is the therapist making the presuppositions of the family overt as they are viewed in the behavior of the family.
- F. **Denominalization** describes the giving of behavioral descriptions for feelings (such as love) in order to determine the individuals' perception of what must happen in order for them to perceive they are receiving that behavior. It is typically language in terms of sensory-based representational systems such as visual, auditory, or kinesthetic.
- G. **Anchoring** is the process of relating a physical stimulus (i.e., a touch on the shoulder) with a previous experience.
- H. **Multiple family therapy** is therapy with several unrelated family systems.

WHITAKER'S EXPERIENTIAL FAMILY THERAPY

I. Important Figures

- A. Major Figure: Carl Whitaker
- B. Secondary Figures: Walter Kempler August Napier
David Keith Fred and Bunny Duhl

II. Overview – Whitaker's Experiential

- A. Experiential therapy emphasizes the immediate here and now.
- B. The focus of therapy is the quality of ongoing experience.
- C. Emotional expression is considered to be the medium of shared experience and the means to fulfillment.

III. Goals of Treatment – Whitaker's Experiential

- A. The aim of therapy is to help individuals grow and to enable them to do so in the context of their families.
- B. To enable family members to experience themselves both as a system and as individuals who are able to become unstuck.

IV. Role of the Counselor – Whitaker's Experiential

- A. The therapist is caring and enters the system. The role of expert is assumed and directives are offered to the client.
- B. The therapist maintains a neutral stance.
- C. Through the phases of therapy, the therapist gradually increases the level of anxiety experienced by the family.
- D. Through paradox, the therapist escalates pressure to produce a psychotic-like episode so the client will reintegrate in a new and meaningful manner.

V. Role of the Symptom – Whitaker's Experiential

Although symptom relief is viewed as important, it is secondary to:

- increased personal integrity
- greater freedom of choice
- less dependence
- expanded experiencing

VI. Normal Family Development

- A. Healthy families are able to self-actualize.
- B. They grow despite the problems and pitfalls they encounter along the way.
- C. They have similar processes of interaction that demonstrate appropriate levels of autonomy and a high degree of role flexibility.
- D. The family members are free to join and separate as they choose.
- E. The family has its own set of stories, and the various systems are open and available for interaction with other systems in their network.
- F. No one family member is the primary symptom-bearer. Each member carries the symptom from time to time.

VII. Development of Behavioral Disorders

- A. Dysfunctional families deny feelings and are either enmeshed or disengaged.
- B. They are self-protective and avoid risk-taking.
- C. They are rigid and mechanical rather than spontaneous and free.
- D. They have a belief that confrontation and open conflict would destroy the family, so the family is unable to grow.
- E. Alienation from experience, leading to a lack of autonomy and intimacy, is the key to a family's dysfunction. It is portrayed both in individual problems and in interpersonal relationships.
- F. The battle for control of whose family of origin will provide the model for procreation also plays a role in dysfunction.

VIII. Key Concepts and Terminology

- A. The model is pragmatic and nontheoretical.
- B. Whitaker refused to create a systematic model. He believed that one should substitute theory with experience and the ability to allow the process of therapy to unfold in an authentic and responsive manner.
- C. The personality of the therapist is a key instrument in therapy.

IX. Techniques – Whitaker's Experiential

A. Three phases of therapy:

1. **Engagement** is the first phase of therapy in which joining takes place.
2. **Involvement** is the longest phase of therapy and involves the highest level of change for the therapeutic process. As the client becomes more committed to therapy, he or she is more invested in change occurring.
3. **Disentanglement** is the final phase of therapy and involves the gradual separation of therapist from client. At this phase, the therapist should have empowered a client and reinforced the need for continued growth.

B. Redefining symptoms as efforts for growth

C. Modeling fantasy alternatives to real-life stress

D. Separating interpersonal stress and intrapersonal stress

E. Adding practical bits of intervention

F. Augmenting the despair of a family member

G. Affective confrontation is the focus on and emphasis on exploration of feelings

H. Treating children like children and not like peers

STRUCTURAL FAMILY THERAPY

I. Important Figures

- A. Major Figure: Salvador Minuchin
- B. Secondary Figures: Harry Aponte Jorge Colapinto
Charles Fishman Braulio Montalvo
Bernice Rosman

II. Overview – Structural

- A. Minuchin offered a theory of family structure.
- B. He believed that families come into therapy because they see themselves as stuck.
- C. Therapy is designed to unfreeze a family from these rigid patterns of behavior and create the opportunity for new structures to emerge.

III. Goals of Treatment – Structural

- A. The goal of structural family therapy is to change the underlying systemic structure of the family and thereby address the presenting problems.
- B. Secondary goals specific to the problem are determined by diagnosis of the structure and the therapeutic stage.

IV. Role of the Counselor – Structural

- A. The therapist becomes an active participant in the system in order to change the structure.
- B. The therapist takes on the role of expert and is active and directive.
- C. The therapist is encouraged to use a flexible approach and integrate his or her personal style.

V. Role of the Symptom – Structural

- A. Typically one family member will serve as the symptom bearer in order to relieve pressure from the dysfunctional family system.
- B. The family is then enabled to focus its attention on the symptom bearer rather than on the pain it is experiencing.

VI. Normal Family Development – Structural

The family develops in stages of increasing complexity. Their task is to blend individual growth with integration as a member of the family system. There are typically four stages of development:

- A. **Couple formation** takes place as two individuals negotiate boundaries with families of origin, reconcile divergent life styles, and develop rules of interaction.
- B. **Family with young children** is the stage in which the marital dyad structure reorganizes to adapt to the role of parents.
- C. **Family with school age and adolescent children** takes the family into a phase of interaction with external systems such as the school system and peers. The family must deal with issues relating to loss of parental control and increasing autonomy of the children.
- D. **Family with grown children** reorganizes its structure from parental to adult-to-adult interaction.

VII. Development of Behavioral Disorders

- A. Behavioral disorders occur when family structures are inflexible and they cannot adjust to the developmental or environmental stressors.
- B. The dysfunction arises because the family cannot realign its structure in order to meet these challenges.
- C. The inflexibility may be due to inherent flaws in the structure or in the ability to transition to the next family stage.
- D. There are four forms of **pathology** associated with the structural perspective:
 - 1. **Pathology of boundaries** in which boundaries are too rigid or too diffuse.
 - 2. **Pathology of alliances** in which relationships that are not conducive to family functioning are either conflict detouring or inappropriate cross-generational coalitions.
 - 3. **Pathology of triad (or triangles)** in which two members have an alliance against a third member.
 - 4. **Pathology of hierarchy** in which a child is parentified and a parent is excluded from the parental subsystem.

VIII. Key Concepts and Terminology – Structural

- A. **Family structure** is the invisible covert set of functional demands or codes that organize the way family members interact with one another.
- It is the internal organization that dictates how, when, and to whom to relate.
 - It is shaped partly by universal and partly by idiosyncratic constraints.
- B. **Family subsystems** are components of a family's structure.
- They exist to carry out various family tasks necessary for the functioning of the system.
 - Subsystems are defined by interpersonal boundaries and rules of membership.
 - Subsystems may be temporary alliances (father and son going to a ball-game) or long-term (parents, siblings).
 - The most common subsystems are spousal, parental, and sibling.
- C. **Boundaries** refer to the invisible barriers that regulate contact between individuals. The degree of **permeability** (on a continuum from rigid to diffuse) determines the level of contact.
1. **Rigid boundaries** lead to impermeable barriers between the subsystems.
 - This results in a **disengaged** family in which the subsystems (typically parent and child) are separate and distinct.
 - Although autonomy is maintained in a disengaged family, it is at the expense of nurturance, closeness, and involvement.
 2. **Diffuse boundaries** are excessively blurred and indistinct.
 - The members typically have little generational hierarchy and parents and children easily trade roles.
 - The system is referred to as being **enmeshed** in which proximity and intensity in family interactions is extreme and family members are overinvolved in each other's lives.
 - Family members have difficulty developing relationships outside the family system.
 3. **Clearly defined boundaries** between subsystems in a family help maintain separateness yet at the same time emphasize connection to the overall family system.

D. Alignments, power, and coalitions

1. **Alignments (or alliances)** are emotional or psychological connections that are defined by the way family members join together or oppose one another.
 - A **triangle** is a dysfunctional alignment. This refers an individual aligning with another against a third individual.
2. **Power** has to do with both authority and responsibility. It refers to the relative influence of each family member on an operation's outcome.
3. **Coalitions** are alliances between specific family members against a third.
 - a. **Stable coalitions** are fixed and inflexible connections that become a part of normal family life.
 - b. **Detouring coalitions** are when a conflictual pair holds a third family member responsible for their difficulties, thus decreasing the stress on themselves or their relationship.
 - c. For parental success, there must be clearly defined:
 - generational boundaries
 - alignments between parents on key issues
 - rules related to power and authority

IX. Techniques – Structural

- A. **Joining and accommodating techniques** are for the purpose of establishing an effective working relationship between the therapist and the client system.
1. **Accommodation** occurs when the therapist modifies their language, tone, or style in order to join with the client.
 2. **Maintenance** is the act of the therapist focusing or highlighting certain behaviors in order to increase the functional aspects of the family structure.
 3. **Tracking** is the use of clarification or amplification of communication to reinforce individuals or subsystems.
 4. **Mimesis** is the adoption of the clients' communication style by the therapist.
- B. **Restructuring techniques** are techniques that directly impact the family structure.
1. **Structural map** is a symbolic representation of a family's structure. It places emphasis on boundaries and coalitions.
 2. **Enactment** occurs when the therapist directs the family to perform an interaction. It can be directly related to the presenting problem or be more benign.
 3. **Escalation of stress** is the heightening of tension in the family in order to force the members to accept the restructuring.
 4. **Boundary making** takes place as the therapist assists the family in setting new boundary rules, renegotiating old rules, or establishing specific functions for each subsystem.
 5. **Utilizing the symptom** occurs when the therapist changes the function of the symptom in the family by encouraging, de-emphasizing, or relabeling it.
 6. **Mood manipulation** occurs as the therapist attempts to change the mood or pacing of the family in order to bring more energy to the session or lead the family to a more reflective frame of mind.
 7. **Support, education, and guidance** takes place as the therapist provides instruction to the family for various presented needs.

STRATEGIC FAMILY THERAPY

I. Important Figures

Jay Haley and Cloe Madanes

II. Overview – Strategic

- A. Strategic family therapy views families as rule-governed systems.
- B. Symptoms are believed to be maintained by the system and, likewise, to maintain the system.
- C. The family is prevented from achieving its purpose as a family by ongoing destructive cycles of interaction.

III. Goal of Treatment – Strategic

- A. The primary goal is to address the presenting problem.
- B. Therapists may also address the relational dynamics connected to the symptom but are to avoid working toward insight into relational processes.

IV. Role of the Counselor – Strategic

- A. The therapist is neutral, directive, and in control of the session.
- B. They take on the role of an expert.
- C. They maintain focus on the problem.
- D. The therapist provides a supportive yet challenging environment.

V. Role of the Symptom – Strategic

- A. Symptoms serve the purpose of maintaining the family system.
- B. The symptom is a strategy used for controlling a relationship when other strategies have failed.
- C. Vying for control is seen as inevitable.
- D. It becomes pathological only when one or both partners deny their attempts to control.

VI. Normal Family Development – Strategic

- A. The family is viewed as developing as it progresses through a family life cycle consisting of the following stages:
 - marriage
 - birth of first child
 - reduction in family size
 - advanced aging
- B. As the family moves from one stage to the next, the functional family is an open system.
- C. Clear boundaries, adaptability, and organization
- D. Parents are at the top of the family hierarchy.
- E. Clear communication is utilized by family members to face the challenges of transition from one developmental stage to the next along with other problems that arise.

VII. Development of Behavioral Disorders

- A. Hierarchical structure is unclear or inappropriate.
- B. Problems are addressed at an inappropriate level in the hierarchy.
- C. Families either deny a problem exists or create a problem where none exists.

VIII. Key Concepts and Terminology

- A. **Hierarchy** is the decision-making structure of a family. It is based on age, gender, roles, or education.
- B. **Alliances and coalitions** are formed by the joining of two family members against a third. This typically disrupts the family hierarchy by placing a child in a parental role.
- C. **Communication** – two levels of communication:
 - 1. **Digital communication** is content-focused communication. This communication is rigid and is typically transmitted to one referent. Difficulty occurs when only digital communication is accepted as relevant without taking other forms of communication into consideration.
 - 2. **Analogic communication** is communication that is conveyed through body language and symbolism. The therapist must have an understanding of this form of communication among individuals in order to view the problem within a relational context.
- D. **Symptoms** are patterns of family interaction that have become problematic within the system. They are the root of the concern that brings the family into therapy.
- E. **Presenting problem** is the problem stated by the family that brings them in for therapy.
- F. **Power** refers to the struggle to be in control and to make the rules of the family.

IX. Techniques – Strategic

- A. **Directives** are assignments given by the therapist to be performed between sessions. They are a key intervention and are either **straightforward** or **paradoxical**.
1. **Straightforward directives** can include advice, explanations, or suggestions. It is expected that the family will **not** resist the task. These directives are designed to change the interactional sequence of the family.
 - **Metaphorical tasks** are tasks given that are not directly related to the problem. It indirectly facilitates change due to the symbolism and content.
 - **Devil's pact** is the commitment a family makes to follow a rigorous task before the task is disclosed by the therapist.
 2. **Paradoxical directives** involve tasks in which success is based on either the family defying the instructions or following them to an absurd extreme and then withdrawing.
 - **Reframe** – The therapist offers an alternative, typically positive, view of the presenting problem. This view impacts the cognitions and behavior of the family.
 - **Prescribing the symptom** – The client is directed to perform the symptomatic behavior. If the client follows the directive, he or she is demonstrating control of the symptom. If he or she resists, they demonstrate he or she can give up the symptom.
 - **Restraining changes** – When the family begins to change, the therapist warns them against changing too fast. This prepares the family for relapse.
 - **Pretend technique** – The identified patient is asked to pretend to have the symptomatic behavior and the other members are asked to pretend to help. This changes the context and places the symptom under their control.
 - **Ordeals** – The therapist prescribes an ordeal that is equal or greater than the distress of the symptom itself. The task makes it more difficult for the family to have the symptom than to give it up.
- B. **Empowerment** is a bolstering of the morale of the family. The therapist reframes the therapeutic context and symptom by focusing on the success they have had.
- C. **Structured interview** – The therapist utilizes interview skills to obtain an assessment and diagnosis of the family system.

BOWEN FAMILY SYSTEMS THERAPY

I. Major Figures

- A. Major Figure: Murray Bowen
- B. Secondary Figures: Thomas Fogarty Edwin Friedman
Philip Guerin Michael Kerr

II. Overview – Bowen’s Model

- A. Bowen believes the main dysfunction manifested in troubled families is emotional fusion. Although people need togetherness, emotional fusion is an exaggeration of this need.
- B. The goal of therapy is a high level of differentiation of self. A person with a high level of differentiation is able to be close to others but maintain a healthy autonomy.

III. Goals of Treatment – Bowen’s Model

- A. Decrease anxiety
- B. Increase differentiation of self
- C. Pay attention to both **process** and **structure**
 - 1. **Process** refers to patterns of emotional reactivity.
 - 2. **Structure** refers to patterns of interlocking triangles.

IV. Role of the Counselor – Bowen’s Model

- A. Coach, researcher, active expert
- B. The counselor becomes the third side of a therapeutic triangle
- C. Works most often with the parental dyad

V. Role of the Symptom – Bowen’s Model

- A. The symptom will typically identify the most vulnerable person in a triangle.
- B. The therapist will utilize this knowledge to identify the participants in the triangle and, beginning with the individual with the highest level of differentiation, work to aid the family in increasing their levels of differentiation.

VI. Normal Family Development – Bowen’s Model

- A. Family members have a high level of differentiation.
- B. Anxiety in the family is low.
- C. Parents have differentiated from their own families of origin.

VII. Development of Behavioral Disorders

- A. The **higher the level of differentiation**, the greater the flexibility and resilience in dealing with stress. The **lower the level of differentiation**, the less stress needed to provoke symptoms.
- B. In order to stabilize the stress-filled system, **triangulation** occurs.
 - If the third party remains neutral, the anxiety lessens and symptoms lessen.
 - If the individual becomes emotionally involved, however, the likelihood of symptom development increases.
 - The most vulnerable person in the triangle (typically a child) is most likely to develop symptoms and be the focus of conflict.

VIII. Key Concepts and Terminology

Eight interrelated concepts:

A. Differentiation of self

1. Differentiation of self is the cornerstone of Bowen's theory.
2. It is the ability to maintain a distinction intrapsychically and interpersonally.
 - The intrapsychic aspect of differentiation involves a distinction between rational thought and emotionality.
 - The interpersonal component refers to the balance between separateness and togetherness.
3. A **high level of differentiation** denotes the ability to maintain a balance on both these continuums.
4. A **low level of differentiation** (also referred to as **undifferentiation**) demonstrates a tendency toward either rationality/emotionality or separateness/togetherness.

B. Triangles

1. Triangles are the basic building block in a family's emotional or relational system.
2. During periods when anxiety is low and external conditions are calm, a two-person system will engage in direct communication.
3. When tension mounts, one or both persons will pull in a third person in order to reestablish stability.
4. The triangle dilutes the anxiety, is more stable and flexible than a twosome, and has higher tolerance for stress.
5. Triangles are typically interlocking and involve an increasing number of people as tension mounts.

C. Nuclear family emotional system

1. Nuclear family emotional system is the manner in which anxiety is projected from individuals onto the family.
2. The lower the level of differentiation of the spouses, the higher the amount of emotional fusion between them.
3. This increased fusion can result in:
 - overt marital conflict
 - reactive emotional distance
 - physical or emotional dysfunction
 - projection of problems onto one or more of the children

D. Family projection process

1. Family projection process refers to the manner by which parents transmit their dysfunction to their children.
2. This transmission of undifferentiation occurs through the triangulation of the most vulnerable child or children.

E. Emotional cutoff

1. Emotional cutoff is extreme emotional distance between two individuals. This typically occurs in a marital dyad.
2. It can also accompany physical cutoff as a child attempts to deal with unresolved emotional fusion with the family of origin.

F. Multigenerational transmission process

1. Multigenerational transmission process describes the process by which severe dysfunction is a result of decreasing degrees of differentiation over several generations.
2. As an individual chooses a spouse with a similar level of differentiation and family projection process occurs, the child will attain a lower level of differentiation.

G. Sibling position

1. Sibling position refers to Bowen's belief that children develop fixed personality characteristics based on their sibling position in their family of origin.
2. These characteristics will be played out in their marriage in relation to the spouse's birth order.

H. Societal regression

1. Societal regression suggests that the emotional process of society impacts the emotional process of the family.
2. As society at large becomes more anxiety ridden, the result is isomorphic with that of the family leading to lower levels of differentiation.

IX. Techniques – Bowen’s Model

A. Genograms

- Genograms are devices for organizing material regarding one’s family of origin.
- The genogram is a schematic drawing listing family members, relationships, ages, dates of birth, marriages, deaths, and other significant information regarding the family and relationship dynamics.

B. Process questions

- Process questions are questions that address the patterns of interaction.
- They are designed to decrease the level of reactivity and give the individuals time to think about their participation in the interpersonal patterns.

C. Therapeutic triangle

- Therapeutic triangle is a triangle including the therapist.
- The therapist remains uninvolved emotionally, and discussion is channeled through him/her.
- This technique enables the therapist to decrease the level of anxiety in the session and model a high level of differentiation.

MILAN SYSTEMIC FAMILY THERAPY

I. Important Figures

Milan group: Mara Selvini-Palazzoli
Gianfranco Cecchin

Luigi Boscolo
Guiliana Prata

II. Overview – Milan Systemic

- A. The model is systemic in nature and views patterns of interaction as being handed down from one generation to the next.
- B. The change process is viewed as important with the family being given a long time between sessions in order to attain the maximum amount of change.
- C. Change of behavior as well as cognition is the focus of therapy.

III. Goals of Treatment – Milan Systemic

- A. The rules of the family game are the focus of therapy.
- B. A primary goal is to aid the family in making the rules overt and gaining control over them.
- C. Although the therapy team may have a goal in mind for the family, the family may create a solution of their own.
- D. Another goal is to help the family understand the role of the symptom in its functioning.

IV. Role of the Counselor – Milan Systemic

- A. The therapist is a participant in the family system.
- B. The therapist views the relationship as recursive in that he/she impacts the family as the family impacts him/her.
- C. Three aspects of the therapist's role:
 - 1. Neutrality
 - 2. Promoting change through prescriptions to change the rules of the family game
 - 3. Making the rules of the game overt
- D. Although the therapist maintains control of the session, he/she should attempt to avoid imposing his/her expert perspective on the client.
- E. The style is nonconfrontational and typically involves a team approach.

V. Role of the Symptom – Milan Systemic

- A. A family member, usually a child, will manifest a symptom in order to protect some of the family members.
- B. It is believed that the symptom serves a function in the system and that the family organizes itself around this symptom.
- C. The symptom is a key to determining the rules of the family game.

VI. Normal Family Development – Milan Systemic

- A. The Milan group has placed minimal emphasis on healthy families and tries to avoid applying preconceived models to families.
- B. They do, however, appear to believe that families should have clear generational boundaries.

VII. Development of Behavioral Disorders

- A. The family game demonstrates the dysfunction of the family.
- B. The game can involve extended family members and take place over a long timeframe.
- C. There are power alliances, typically across generations, that make up the rules of the game and maintain it.

VIII. Key Concepts and Terminology

A. Circularity

- Circularity refers to the recursive nature of living systems.
- This concept was the underlying foundation for neutrality, hypothesizing, and circular questioning.

B. Hypotheses

- Hypotheses are explanations offered by the team regarding the role of the symptom in the family and how the family organizes around it.

C. Significant system

- Significant system refers to the system that is organized around the presenting problem.
- This can involve the family, the school, friends, etc.

D. Positive connotation

- Positive connotation is the belief that symptoms serve a logical and purposeful function within the system.

E. Family games

- Family games are the organizational patterns around which a family interacts.
- Symptoms may arise when one of these patterns is affecting a family member in a detrimental manner.

F. Alliances

- Alliances are connections between two individuals that may exclude a third.
- These alliances can be healthy (as in two parents) or pathological (a parent and a child).

IX. Techniques – Milan Systemic

A. Standard treatment process

1. Telephone interview

2. Pre-session meeting

- Pre-session meeting of the team in order to formulate initial hypotheses.

3. SESSION 1

- Session 1 involves an interview of the extended family and friends while the team observes.
- Both the therapist and team gather information regarding the rules of the family game.
- The therapeutic system takes a break in order for the team to revise its hypothesis and prepare the prescription.
- The prescription is given to the family in the form of a positive connotation.

4. SESSION 2

- Session 2 involves only the nuclear family.
- Changes in the family are recognized and assessment occurs on issues more specific to the nuclear family.
- This session involves:
 - a. a connecting phase
 - b. an analysis phase
 - c. a testing phase

5. SESSION 3

- Session 3 focuses on the parents alone.
- Assessment continues, and the team gives the parents a prescription for change.

6. SESSION 4

- Session 4 through the final session focuses on reviewing parental observations regarding the prescription and addressing responses to additional prescriptions provided by the team.

B. Other techniques included in the sessions

1. **Prescriptions**

- Prescriptions – a paradoxical injunction in which the therapist directs the family members to perform the symptomatic behavior.
- If the family follows the prescription, the symptom is under their control.
- If they do not follow it, they give up the symptom.

2. **Rituals**

- Rituals are prescriptions that engage the family in a series of actions that run counter to or exaggerate the rigid family rules or beliefs.

3. **Positive connotation**

- Positive connotation is a reframing of the symptom.
- The therapist attributes positive motives to the symptomatic behavior.
- It is typically stated that the symptom serves the purpose of maintaining the rules of the family game.

4. **Circular questioning**

- Circular questioning is a process of asking questions designed to let clients see themselves in a relational context and to see that relational context from the perspective of other family members.
- Questions are structured in a manner that one must give a relational description in the answer.

5. **Hypothesizing**

- Hypothesizing is central to the Milan model.
- The therapists speculate about the role of the symptom and the manner in which the family is organized around it.
- This occurs before the family comes to the initial session and throughout the therapeutic process.
- If the team does not have a hypothesis ahead of time, it is believed that they may “buy into” the family’s problem definition.

COGNITIVE BEHAVIORAL FAMILY THERAPY

I. Important Figures

- A. Major Figures: Albert Ellis Aaron Beck
- B. Secondary Figures: Donald Baucom
 Frank Datillio
 Norman Epstein

II. Overview – Cognitive Behavioral

- A. Cognitive-Behavioral Family Therapy is based on behavioral therapy that teaches the concepts of classical conditioning and operant conditioning.
- B. Operant conditioning is suited for families in that it addresses reinforcement.
- C. Operant conditioning espouses that behaviors that are positively reinforced will be repeated and behaviors that are punished or ignored will be extinguished.
- D. CBFT is based on the premise that behavior is maintained by its consequences.

III. Goals of Treatment – Cognitive Behavioral

- A. Rather than focusing on systemic change, the goal of CBFT is to eliminate undesirable behavior and increase positive behavior.
- B. The family determines the desired change, typically in the form of a presenting problem.
- C. The therapist empowers the family to solve their own problems through education and assistance via increased understanding.
- D. Focus on cognitions occurs as the therapist teaches the family that emotional problems are caused by irrational beliefs and that by changing these distortions overall quality of life will improve.

IV. Role of the Counselor – Cognitive Behavioral

- A. The therapist takes on a directive role as the expert on behavior and cognitions. The therapist models appropriate behavioral strategies for communication and conflict resolution.
- B. Another task the therapist acquires is that of assessing the cognitive distortions of the client and educating them on more appropriate ways to handle their thought processes.

V. Role of the Symptom – Cognitive Behavioral

Symptoms are considered to be learned responses. They are involuntarily acquired and reinforced. The symptoms are the focus of therapy. They lead to the responses of the family members that reinforce the symptomatic behavior.

VI. Normal Family Development

- A. The focus of Behavioral theorists is on the current behavior.
- B. Little attention is given to past development, either normal or dysfunctional.
- C. A good relationship is viewed as having a balance of give and take.
- D. There is an exchange of pleasant behavior and minimal unpleasant behavior.
- E. Communication skills are considered to be the most important feature of good relationships.
- F. Conflict resolution is also deemed vital to the maintenance of healthy relationships.
- G. Family schemata, as taught by the parents' families of origin, are applied to the marriage and to the rearing of children.

VII. Development of Behavioral Disorders

- A. Behavioral disorders develop as a result of reinforcement by family members.
- B. Illogical beliefs and distortions are the foundation of emotional distress.
- C. Four means by which a family's cognitions, behavior, and emotions may interact and build a volatile climate:
 - 1. The individual's own cognitions, behavior, and emotion regarding family interaction
 - 2. The actions of individual family members towards him or her
 - 3. The combined reactions several family members have toward him or her
 - 4. The characteristics of the relationships among other family members

VIII. Key Concepts and Terminology

A. Behavioral

1. Operant responses (causes)

- Operant responses (causes) are responses not automatically elicited by stimuli.
- Their occurrence is affected by their consequences.

2. Respondent responses (effects)

- Respondent responses (effects) are those under the control of stimuli.
- Their consequences do not affect the frequency of occurrence.

3. Reinforcements

Reinforcements are consequences that affect the rate of behavior, either accelerating or decelerating it.

a. Reinforcers are consequences that **accelerate** behavior.

- Negative reinforcers are aversive consequences.
- Positive reinforcers are rewarding consequences.

b. Punishers are consequences that **decelerate** behavior.

- Aversive control is the implementation of a negative reinforcer such as spanking.
- Withdrawal of positive consequences refers to the absence of positive reinforcers.

4. Extinction

- Extinction occurs when no reinforcement follows a response.
- The cessation is not immediate.

5. The Theory of Social Exchange

- The Theory of Social Exchange says that people maximize profits and minimize costs.
- In a functional relationship, the individual partners attempt to maximize a rewarding relationship.
- In a dysfunctional relationship, both partners focus on self-protection rather than maximizing the happiness of their partner.

B. The Cognitive-Behavioral approach

The Cognitive-Behavioral approach balances an emphasis on cognitions and behavior.

1. Family relationships, cognitions, emotions, and behavior are believed to exert mutual influence on each other.

- Members of a family influence and are influenced by each other.

2. Family schemata are beliefs the family members have about the family.

- a. The beliefs are formed through years of interaction among the different members.
- b. Two separate sets of schemata are maintained:
 - Beliefs regarding family of origin
 - Beliefs about families in general

IX. Techniques – Cognitive Behavioral

A. Operant Techniques

1. Shaping

- Shaping occurs when there is a deliberate attempt to create a new response.

2. Contingency contracts

- Contingency Contracts involve the parents agreeing to make certain changes if a child makes certain agreed upon changes.

3. Contingency management

- Contingency management consists in giving or taking away rewards or punishments based on the behavior of the child.

4. Token economies

- Token economies utilize a system of stars or points to reward a child for successful behavior.

5. Time out

- Time out is a punishment in which a child must sit in a corner or a room for a specified length of time.

B. Respondent conditioning

- **Respondent conditioning** involves modification of physiological responses.
- This can include desensitization, assertiveness training, aversion, and sex therapy.

C. Cognitive affective techniques

1. Thought-stopping

- Thought-stopping involves the raising of awareness of automatic thoughts with the intent of gaining control over them.
- The client is taught methods to replace these automatic thoughts with more balanced cognitions.

2. Rational emotional emphasis

- Rational emotional emphasis is to help family members see how illogical beliefs and distortions serve as the foundation of their emotional distress.
- As the individual addresses these distortions, the emotional intensity with which they deal will decrease.

BRIEF SOLUTION FOCUSED FAMILY THERAPY

I. Important Figures

- A. Major Figures: Steve deShazer Insoo Berg
- B. Secondary Figures: Eve Lipchik Michelle Weiner-Davis
Bill O'Hanlon John Walter
Jane Peller

II. Overview – Brief Solution Focused

- A. The solution-focused model is based on the belief that when the focus is drawn to exceptions or solutions to problems, change is more likely.
- B. Problem cause is de-emphasized, and therapy tends to be brief and goal-focused.

III. Goals of Treatment – Brief Solution Focused

- A. The goal of solution-focused therapy is to help clients resolve their complaint by helping them change their focus.
- B. This leads to a different perspective and a greater level of satisfaction with their lives.
- C. The therapist believes that this perspective becomes apparent once clients begin moving toward their desired goal.
- D. It is necessary, therefore, for a goal or goals to be determined early in therapy.

IV. Role of the Counselor – Brief Solution Focused

- A. The therapist is viewed as a partner in the therapeutic process.
- B. Although he/she is directive regarding the shift in focus, the family is viewed as the experts of their situation.
- C. The therapist emphasizes exceptions and solutions in a warm and caring manner.
- D. Change is expected, and therapy is brief.

V. Role of the Symptom – Brief Solution Focused

- A. The symptom or complaint is what brings the family to therapy.
- B. It is used to enable the family to focus on when the complaint does not occur and the times the family is successful.
- C. Although the symptom may be incorporated into the goal formulation, it is de-emphasized as the family shifts their focus to solutions.

VI. Normal Family Development

- A. Families are not viewed as functional or dysfunctional.
- B. Through his/her belief in multiple realities, the therapist does not want to impose his/her perspective of what is normal.
- C. The therapist is interested in language and the way language is utilized to provide a description of the complaint.

VII. Development of Behavioral Disorders

- A. As is consistent with the solution focus of therapy, therapists themselves focus on how families are effective rather than on what they are doing wrong.
- B. Solutions to problems are viewed as separate from problem formation.
- C. It is, therefore, unnecessary to try to determine causality.

VIII. Key Concepts and Terminology

A. Focus on solutions

- Focus on solutions shifts attention from the problem to the solution.
- This can take the form of addressing attempted solutions that do not work, but it primarily helps the client have a future-oriented focus on what he/she can do rather than what he/she does not want to do.

B. Death of resistance

- Death of resistance refers to the belief that there is no resistance.
- Clients want to change, and what therapists view as resistance is in reality communication regarding what works and what does not work.
- Therapy is collaborative and flexible to deal with each client type.

C. Complaint

- The complaint is considered to be the presenting problem.

D. Client types

1. Visitors

- Visitors are in therapy because it is mandated or because someone has brought them.
- They have no complaint and are welcomed but not given an assignment.

2. Complainants

- Complainants expect a solution for their complaint but do not believe they need to change.
- They are typically given an observational assignment.

3. Customers

- Customers are those clients that come in with a complaint and are prepared to change.
- **The goal with all clients** is to help them move to this frame of mind.

E. Therapeutic fit

- Therapeutic fit refers to the joining process of therapy.
- The therapist communicates understanding of the complaint in a nonjudgmental manner.

F. Small change leads to large change

- It is believed that a small change in the system is all that is needed to enable a client to reach his/her goals.
- Change occurs quickly once initiated.

G. Constructivism

- Constructivism is the belief in multiple realities and that these realities are co-created. Constructivist therapists believe that language shapes reality.
- The therapeutic process enables the client to envision multiple solutions, none of which is more correct than another.

IX. Techniques – Brief Solution Focused

A. Negotiation of Goals

- Negotiation of goals emphasizes the belief that clients want to change and that if they have a clear, attainable goal, they will move toward it.

B. Exceptions

- Exceptions are times when the problem does not take place.
- The therapist directs the attention of the client toward times when the problem does not take place in hopes of encouraging more frequent exception-oriented thinking.

C. The formula first session task

- The formula first session task is a homework assignment routinely given in the first session.
- The client is asked to observe the exceptions or what happens in his/her relationship that he/she wants to continue.

D. Questions

1. The Miracle Question

- The Miracle Question is a question asked for the purpose of clarifying the goal(s) the client wants to achieve.
- The client is asked to imagine that while he/she was sleeping a miracle happened and the problem was solved.
- The client is asked to describe what would be different?

2. Scaling Questions

- Scaling Questions aid in clarification of ambiguous goals or feelings.
- An example is “on a scale of one to ten with one being the way you felt when you called and ten being the way you would feel after the miracle, how do you feel right now?”
- “What would move you from a 2 to a 3?”

3. Coping Questions

- Coping Questions focus on the strengths of the client.
- The therapist asks the client what he/she has done to be able to cope with the problem.
- As the client answers, the therapist is noting the strengths the client describes.

E. Normalizing

- Normalizing occurs as the therapist aids the client in understanding that others experience what he/she is experiencing.
- This aids the client in perceiving that he/she is normal rather than pathological or hopeless.

NARRATIVE FAMILY THERAPY

I. Important Figures

- A. Important Figures: Michael White David Epston
- B. Secondary Figures: Alan Parry Robert Doan

II. Overview – Narrative

- A. Narrative family therapy comes from a social constructionist perspective.
- B. It utilizes the metaphor of a narrative to help clients understand that they can overcome the problem-saturated story of their lives and embrace a new story.
- C. The importance of language is stressed and clients are shown how language can oppress or liberate an individual through the process of therapy.

III. Goals of Treatment – Narrative

- A. The goal of therapy is to enable people to write a new story that emphasizes their preferred ways of relating to themselves and to others.
- B. This is accomplished by removing the problem from their identity through externalization of the problem.
- C. A new story is authored through deconstruction of the problem-saturated story and reconstruction of a new narrative.

IV. Role of the Counselor – Narrative

- A. The therapist has a collaborative stance and views the family as having expertise regarding their story.
- B. The role of the counselor, therefore, is that of an editor or publisher.
- C. The counselor has expertise in drawing out the story of the client and helping him/her to reauthor that story.

V. Role of the Symptom – Narrative

- A. The symptomatic behavior is based on a belief in the reality of the problem-saturated story.
- B. As long as the client accepts an identity based on this story, he/she will act accordingly.
- C. When his/her perspective of himself/herself changes to a more positive frame, he/she is free to act in a manner that does not include the problem.

VI. Normal Family Development – Narrative

- A. Narrative therapists avoid imposing standards of what is normal or abnormal. It is believed that these standards are oppressive to marginalized populations. Narrative therapists avoid placing labels or diagnoses on people as it is believed this encourages the therapist to view individuals as objects.
- B. Nichols and Schwartz (2001, p. 395) state that narrative therapists believe “people:
 - have good intentions — they don’t want or need problems,
 - are profoundly influenced by the discourses around them,
 - are not their problems, and
 - can develop alternative, empowering stories once separated from their problems and from the cultural common wisdom they have internalized.”

VII. Development of Behavioral Disorders

- A. The manner in which people see themselves is shaped by the dominant discourses of the culture.
- B. These stories are typically problem-saturated and influence the thinking and behavior of the individual as long as he/she remains unchallenged.

VIII. Key Concepts and Terminology

A. Storying of experience

- Storying of experience is the organization and the meaning attributed to one's experiences.
- As the story is authored, it serves as a basis for shaping further understanding and experience.

B. Unconditional positive regard

- Unconditional positive regard refers to the non-judgmental acceptance of another's story as significant and true.

C. Alternative stories

- Alternative stories are the new stories that unfold as the client becomes aware that he/she is separate from his/her problem and that there are unique outcomes to the description of his/her story.

D. Language

- Language is a key tool in narrative family therapy.
- Through language, the old story is deconstructed, and the new story is authored.

E. Dominant discourses

- Dominant discourses are the cultural messages that can either empower or subjugate various subgroups.
- These messages are internalized and form the basis for one's problem-saturated story.

F. Power

- Power is viewed as an important concept at several levels.
- The therapist is aware of the subjugation of marginalized groups by the dominant discourses.
- It is important to also maintain awareness of the power differential within the therapeutic relationship.

G. Problem-saturated story

- Problem-saturated story is the understanding that individuals attribute to themselves.
- This perception tends to be dominated by problems to the exclusion of those times when the problem is not present.

H. Multiple realities

- Multiple realities refers to the postmodern perspective that one perception of reality is no more valid than any other.
- This impacts the therapeutic context in that the therapist views the reality of the client as being just as valid as his/her own view of reality.

I. Unique outcomes

- Unique outcomes are the successes or victories that have been obscured by the problem-saturated story.
- The therapist draws attention to these victories in order to aid in the reauthoring of the person's story.

IX. Techniques – Narrative

A. Tracking

- Tracking refers to the process of close attending to the client and his/her story.
- This is a joining technique.

B. Normalizing

- Normalizing is a technique utilized by several models of therapy in which the stigmatizing effects of a problem are decreased by providing evidence that others have similar difficulties.

C. Deconstruction

- Deconstruction is the dismantling of a problem through an analysis of its credibility.

D. Presupposition of change

- Presupposition of change is the intentional use of language that conveys the inevitability of change.

E. Externalization

- Externalization of a problem removes it from the identity of an individual.
- This process portrays the problem as a living entity that is attempting to control the client.
- If a couple or family is the client system, **patterns of interaction** can be externalized.

F. Locating unique outcomes

- Locating unique outcomes refers to the emphasis placed on the times when the problem is not occurring.
- There are three types of unique outcomes based on how they are placed in time:
 1. historical unique outcomes
 2. current unique outcomes
 3. future unique outcomes

G. Restorying/reauthoring

- Restorying/reauthoring is the process of giving new meaning to the experiences one has lived.
- The therapist serves as editor to encourage and to aid the client in rewriting his/her previous story.

H. Using the audience or witnessing

- Using the audience or witnessing means inviting others to be involved in solidifying the new story.
- Others are asked to play a specific role that will enhance the chances that the client will view himself/herself in a different manner.

INTEGRATIVE MODELS

I. Important Figures

William Pinsof	Joseph Eron	Thomas Lund
Richard Schwartz	Neil Jacobson	Andrew Christensen

II. Overview – Integrative Models

- A. Integrative family therapy refers to a formal decision-making process by which techniques are borrowed from a variety of models. There is no single integrative model, rather there are numerous efforts to construct new models.
- B. The term “integration” refers to three approaches:
 - 1. **Eclecticism** draws from a variety of approaches.
 - 2. **Selective borrowing** in which techniques or concepts are taken from models to compliment one primary model.
 - 3. **Specially designed integrative models** are theoretical models that draw on several approaches.

III. Goals of Treatment – Integrative Models

- A. When therapists combine aspects from a number of models, they achieve **increased comprehensiveness**. The previously outlined models typically have a narrow focus on a certain area. Integrative models usually draw understanding into a wider range of phenomena thus increasing the requisite variety of the therapist.
- B. Another goal is to expand the horizons of understanding without losing focus. Rather than create an entirely new model, theorists can utilize the previously organized concepts and enhance their usefulness.

IV. Role of the Counselor – Integrative Models

- A. The role of the counselor will vary based on chosen models of integration.
- B. The stance of the counselor is typically more collaborative in nature.

V. Role of the Symptom – Integrative Models

The role of the symptom is assessed through the lens of the models integrated into the new approach.

VI. Normal Family Development

- A. The conceptualization of family development is based on the chosen models. For example, with Integrative Problem-Centered Therapy, Pinsof first views a family from a strategic lens then through the experiential model of Satir. The family is then analyzed from a psychopharmacological perspective and finally from a transgenerational point of view.
- B. Other integrative models will utilize the concepts from two models and stay within the premises of those models (such as the Narrative Solutions Model by Eron and Lund).

VII. Development of Behavioral Disorders

- A. Behavioral disorders are assessed through the lens of the models integrated into the new approach.
- B. An understanding of the initial models aids in understanding of behavioral disorders. For example, from the perspective of Internal Family Systems by Richard Schwartz, disorders occur as the individual family members lose sight of their core selves. From a multiplicity perspective, the various parts of the personality take over leadership and hide the core self. From a systems perspective, the various parts have begun to interact in a dysfunctional manner.

VIII. Key Concepts and Terminology

- A. Cross model boundaries
- B. Combine theoretical or technique elements from various models
- C. Focused on client and presenting problem
- D. Identify generic elements of treatment
- E. Reflect a broad view of the change process
- F. Appreciate diversity of thought in the field
- G. Pragmatic in nature
- H. Focus on one or more systems' elements (individual, couple, family)
- I. Emphasize the self-of-the-therapist

IX. Techniques – Integrative Models

- A. There are no specific techniques that are applied to all integrative models.
- B. A larger repertoire of techniques allows the therapist to have a great requisite variety from which to choose.
- C. However, technique selection is deliberate and should follow the formal integration which has already occurred within the various models.

COMMUNICATIONS MODEL

I. Important Figures

- A. Major Figures: Don Jackson Jay Haley
- B. Secondary Figures: Paul Watzlawick John Weakland

II. Overview – Communications Model

Communication theorists are concerned with three aspects of communication as they relate to the family:

- A. **Syntax** – the style or manner in which information is transmitted and received
- B. **Semantics** – the clarity of communication transmission and reception
- C. **Pragmatics** – the behavioral effects of communication

III. Goals of Treatment – Communications Model

- A. The goals of treatment are individuation of members and improved relationships.
- B. An individual focus is assumed with the belief that as individuals grow they will develop greater family cohesion.
- C. Improved communication is the primary method used to promote healthy relationships by altering poorly functioning patterns of interaction.
- D. Theorists believe that these alterations will block symptomatic behavior, thus leading to its replacement by functional behavior.

IV. Role of the Counselor – Communications Model

- A. The therapist has a directive approach and remains in control of the session.
- B. The therapist's behavior ranges from warm and collegial to more hierarchical and distant.

V. Role of the Symptom – Communications Model

The role of the symptom according to communications therapists is to maintain the homeostatic equilibrium of family systems.

VI. Normal Family Development

- A. Communication family therapy focuses on the present rather than the past. It has little interest in development. It is interested, however, in negative and positive feedback loops and their influence on the patterns of interaction.
- B. **Negative feedback loops** refer to the relationship balance achieved despite environmental influences. When the family begins to be unstable, a regulatory system “kicks in” to bring it back to a comfortable level of homeostasis.
- C. **Positive feedback** alters the system to accommodate to changing circumstances. Flexible families are able to maintain stability but also modify their rules when the need arises.

VII. Development of Behavioral Disorders

- A. Symptomatic behavior occurs due to the rigidity of the system and its rules.
- B. Families become trapped in rigid homeostatic patterns of communication and are unable to adjust to change.
- C. Change is viewed as threatening, and the system resists it.
- D. As a family member attempts to change, the family attempts to restore homeostasis by labeling him/her as sick.

VIII. Key Concepts and Terminology – Communications Model

- A. **Metacommunication** refers to communicating about communication. It involves several axioms:
 - 1. People **cannot not communicate**.
 - 2. All messages have a **report** and a **command** function.
 - The **report** deals with the content of the message.
 - The **command** focuses on the definition of the relationship.
 - 3. Command messages are the **rules** or the regular patterning of interactions. They function to stabilize relationships.
 - 4. **Family homeostasis** is the behavioral balance within a family. It is preserved by the family rules. Thus, families are viewed as rule-governed systems.
 - 5. **Complementary relationships and symmetrical relationships** are terms used to describe relationships between communicants.
 - **Complementary relationships** are based on differences that fit together.
 - **Symmetrical relationships** are based on equality. Behavior of one individual mirrors that of the other.
 - 6. Communication is **punctuated** in various manners. Punctuation organizes behavioral events and reflects the bias of the observer (Nichols & Schwartz, 2001, p. 69-70).
- B. **Circular causality** is assumed, and the therapist focuses on patterns of interaction rather than underlying causality of symptoms.

IX. Techniques – Communications Model

- A. **Teaching rules of clear communication** refers to straightforward directives by the therapist to aid in more functional patterns of communication. A few of the most common are as follows:
 - 1. Speak in first person singular
 - 2. Make personal statements (I-statements)
 - 3. Speak directly to, not about, each other
- B. **Analyzing and interpreting communication patterns** involves assisting the client in understanding his/her faulty rules and patterns.
- C. Manipulating interactions through **strategic interventions** was viewed by some therapists as the only way to move the client system toward change.
 - 1. **Reframing** was redefining the communication of the family with an emphasis on a positive aspect of the relationship.
 - 2. **Therapeutic paradox** refers to assigning the completion of a task that is in direct conflict with the expressed desires of the client system. If the client follows the directive, the symptom is under his/her control. If he/she resists, the symptom has stopped.
- D. Make the dysfunctional rules explicit in order to make them more difficult to follow.

MISCELLANEOUS INFORMATION

1. **Boundaries:** Nichols – The emotional barriers that protect and enhance the integrity of the individual, subsystems, and families.

Minuchin – Invisible barriers in the family that regulate the amount of contact between people.
2. **Communication theory** – A theory of relationships in terms of the exchange of verbal and nonverbal messages.
3. **Concurrent therapy** – The treatment of two or more related persons seen by separate therapists.
4. **Conjoint Family Therapy** — A therapeutic approach, devised by Don Jackson, in which the whole family is the therapeutic unit for treatment and the family members meet as a group with the therapist to change family interaction (Sauber, et. al., 1993, 76).
5. **Conjoint therapy** — Satir – The treatment of two or more members together.
6. **Cybernetics** — The study of common processes in systems, especially analysis of the flow of information in closed systems. The cybernetic model is important to family theorists because it introduces the idea of circular causality by way of the feedback loop. Cybernetics focuses on the interaction between the parts of the system and holistic patterns. First-order cybernetics assumes the system being observed is separate from the observer. Second-order cybernetics emphasizes the observer (therapist) as part of the system (also referred to as cybernetics of cybernetics).
Example: A husband may be convinced that his wife's nagging (cause) makes him withdrawn (effect). She is equally likely to believe that this withdrawal causes her to nag. (Sauber, et. al., 1993, 90-91)
7. **Disengaged family** — An extreme family type in which each family member is cut off emotionally from the other. There is little interaction, exchange of feelings, or sense of belongingness. There is relative absence of connections, and relationships between family members are weak or nonexistent. The enmeshed family, by contrast, is characterized by a tight interlocking of its members.
Example: The father is involved with his work, the mother with church activities and various volunteer and charitable organizations. One child belongs to the Boy Scouts and is working on a Eagle Scout badge, while another child skips school and acts out in predelinquent ways. (Sauber, et. al., 1993, 104)
8. **Disengagement** — Minuchin – The rigid boundaries that result in relatively isolated and autonomous ways of relating. Extreme stress must be present for family members to ask for support.
9. **Double-bind** — MRI Group, especially associated with Bateson - A conflict created when a person receives contradictory messages on different levels of abstraction in an important relationship, and cannot leave or comment.
10. **Dyadic** – The interaction between two persons or objects.

11. **Enmeshment** — Minuchin – The loss of autonomy due to blurring of psychological boundaries.
12. **Family of origin** – The person's parents and siblings.
13. **Fusion** – The blurring of psychological boundaries between self and others.
14. **Genogram** – A schematic drawing of the relationships within a family.
15. **Homeostasis** – A balanced steady state of equilibrium.
16. **Identified patient (IP)** – The official patient as identified by the family.
17. **Helen Kaplan** — guru of treating sexual dysfunction
18. **Linear causality** – The idea that one event is the cause and another is the effect.
19. **Multiple impact therapy** — MacGregor – An intensive, crisis-oriented form of family therapy; family members are treated in various subgroups by a team of therapists.
20. **Mystification** — Laing - A concept that many families distort their children's experience by denying or relabeling it.
21. **Nuclear family** – Parents and their children.
22. **Object relations** – Internalized images of oneself and others based on early parent-child interactions which determine a person's mode of relating to others.
23. **Parental child/Parentified child** – A child who has been allocated power by the parent to take care of younger siblings.
24. **Premack principle** – The use of high probability behavior (preferred activities) to reinforce low probability behavior (nonpreferred activities).
25. **Process/content** – The distinction between a way of relating and what is being said.
26. **Propinquity** — Means nearness or proximity. The propinquity theory of mate selection “asserts that nearness or being in close proximity is a major factor in mate selection. This theory suggests we are apt to select a mate with whom we are in close association, such as at school or at work or whom we meet through neighborhood, church, or recreational activities.” (Rubin, 1973, p. 251)
27. **Scapegoat** — Boszormenyi-Nagy – A person who is the object of displaced conflict for the family.
28. **Sculpting** — Duhl – The placing of family members in postures that non-verbally state their role in the family.
29. **Separation-individuation** – The process of separating from the mother in order to become autonomous.
30. **Triangles** — Nichols - A three-person system; the smallest stable unit of human relations.
31. **Triangulation** – The detouring of a conflict between two people by involving another person.

Chapter 7

Consultation

CONSULTATION

NCE – Chapter 7

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CONSULTATION

NCE – Chapter 7

DEFINITIONS AND CONTEXT

I. Definitions

- A. Consultation involves three parties at minimum (Caplan, 1970):
- the consultant
 - the consultee
 - the client
- B. Dougherty (2000) defines consultation as ". . . a process in which a human services professional assists a consultee with a work-related (or care-taking related) problem with a client system, with the goal of helping both the consultee and the client system in some specified way" (p. 9).

II. Context

- A. Consultation in the counseling field is becoming a specialized practice in which professionals collaborate to improve the mental health of individuals or the functioning of groups or organizations (Brown, 1993). Almost every profession has members of that profession serving as consultants to other members of that profession. Consultation is not a specialty unique to the counseling profession.
- B. Consultation can be viewed as an indirect service because the consultant helps the consultee (the professional) to work more effectively with those who are receiving services.
- C. The consultee may be a number of professionals comprising an organization or agency, such as a mental health service agency.
- D. The client may be any individual or group that is receiving direct services from the consultee(s).
- E. Remley and Herlihy (2001) distinguish between two specific contexts:
- **peer consultation** – consulting with an individual
 - **organizational consultation** – consulting with organizations such as businesses, agencies, or schools

MODELS OF CONSULTATION

Consultation may emphasize content or process (Austin, 1999).

1. **Content-oriented consultation** focuses on the transfer of knowledge or information from the consultant to the consultee. The consultant is considered an expert and assumes the role of problem-solver.
2. **Process-oriented consultation** focuses on how and why problems are occurring. The consultant is more of a facilitator who may use communication, attribution, change, or motivational theories to help the consultee or organization make changes.

THE FOLLOWING MODELS MAY EMPHASIZE ONE OR BOTH OF THESE TYPES OF CONSULTATION.

I. Caplan's Model of Consultation

A. Mental Health Consultation Model

1. Gerald Caplan's (1970) **mental health consultation model**, based on a psychodynamic perspective, is the prototype for most counseling consultation models used today.
2. Caplan proposed that professionals need consultation when there is a deficit in:
 - skills
 - self-confidence
 - knowledge
 - objectivity
3. The **loss of objectivity**, the most frequent reason for a request for consultation, is attributed to the consultee identifying with the client's problem or to a psychological impairment of the consultee.
4. Such loss of objectivity is described as "theme interference" (Caplan, 1970; Caplan and Caplan, 1999).

B. Four Consultation Relationships

The focus of consultation can be (Caplan, 1970; Caplan and Caplan, 1999):

1. **Client-centered consultation** involves the consultee seeking assistance from a consultant about a client.
2. **Consultee-centered consultation** concentrates on the consultee's overall professional deficits.
3. **Program-centered consultation** involves a consultant helping with an organizational problem.
4. **Consultee-centered administrative consultation** focuses on improving the consultant's administrative problem-solving skills or other broad areas of skill deficits or emotional entanglements with a specific issue.

II. Schein's Model of Consultation

- A. Edgar Schein's (1969) model is a process model that emphasizes group-dynamics and communication processes within organizations.
- B. Process consultation is also known as **organizational development**.
- C. Schein (1969) recommended the following seven interacting and overlapping steps to process consultation:
 - 1. initial contact with the client organization
 - 2. definition of the consultation relationship, including both the formal and psychological contracts
 - 3. selection and setting of a method of work
 - 4. data gathering and diagnosis
 - 5. intervention
 - 6. involvement reduction
 - 7. termination
- D. Process consultants are usually not experts in the field of their consultees. Rather, they provide expertise in interpersonal process (e.g., communication) within an organization.
- E. Process models of consultation are sometimes called "purchase" or "purchase of expertise" models (Austin, 1999; Schein, 1978).

III. Behavioral Model of Consultation

- A. This model is a problem-solving model based on social-learning theory.
- B. It employs the use of traditional behavior modification techniques (e.g., shaping, chaining, modeling, etc.) and is particularly well-suited for such controlled environments as:
 - 1. schools
 - 2. prisons
 - 3. hospitals
- C. The model may use the following general steps:
 - 1. identify target behavior
 - 2. isolate environmental variables supporting target behavior
 - 3. develop a plan to change environmental conditions
 - 4. implement plan
 - 5. evaluate

IV. Training Model of Consultation

- A. The training model of consultation is usually in the form of workshops in which educational methods are used to impart information and to develop skills.
- B. These workshops may take the form of retreats or "in-service" opportunities, have clearly defined purposes, and are usually preventative in nature (Vacc & Loesch, 2000).
- C. If problem areas are not identified before the consultant is called upon, the consultant typically surveys the group to determine concerns, and he/she designs the workshop based on responses.
- D. The workshop itself is usually conducted utilizing a variety of experiential techniques.

V. Other Models of Consultation

The consultation literature includes a variety of other models. These include the following:

A. Systems Models

- Systems Models focus on the complex interactions and interconnectedness of elements of human organizations; organizations create the very environment in which, and to which, they respond (Fuqua & Kurpius, 1993).
- Systems theory may be the most often applied framework for consultation (Ridley & Mendoza, 1993).

B. Kurpius, Fuqua, and Rozecki's (1993) Model

- This model emphasizes behavioral or structural change through careful analysis of the problem and synthesis of alternatives.

C. Atheoretical Problem-Solving Consultation

1. This model emphasizes an atheoretical approach that relies heavily on facilitative communication skills and systematic problem-solving.
 2. This approach suggests four steps (Vacc & Loesch, 2000):
 - a. Identify the problem
 - b. Clarify the consultee's situation (what has been done so far, feelings, expectations, attitudes, etc.)
 - c. Identify the goals and desired outcomes
 - d. Develop a plan
 3. The traditional approach to consultation has focused on problem-solving or remediation of the person or organization.
 4. Recent emphasis has been on the growing impact of strategic planning concepts and models (Kurpius & Fuqua, 1993).
 - a. The strategic planning approach focuses on developing a futuristic "vision" to guide organizational development.
 - b. The developmental potential of the organization and prevention are emphasized rather than solving internal problems, though strategic planning may address problem issues as well.
- Contextual and situational factors, such as the openness or closedness of a system and its readiness for change, should determine which type of model is used (Kurpius & Fuqua, 1993; Kurpius, Fuqua, Rozecki, 1993).

ESTABLISHING THE CONSULTATION RELATIONSHIP

I. Three Important Issues

A. There are three important issues related to the consultation relationship (Doherty, 2000):

1. Work-related Focus

- Consultation should focus on work-related issues rather than personal issues of the consultee, though this is often a difficult line to draw.

2. Dual Relationships

- The two most common dual roles that may occur in consultation are combining consultation with supervision or combining consultation with counseling.
- The consultee should be referred for assistance when counseling is needed.

3. Freedom of Choice

- Consultation is essentially a peer relationship, while supervision assumes a hierarchy that creates a power differential and includes the need to evaluate.
- Freedom of choice is related to the peer relationship of consultation because the consultee is encouraged to be self-determined by choosing to do whatever he/she wishes with the consultant's recommendations.

B. Consultation is usually a short-term professional relationship with a fairly narrow focus (Austin, 1999; Doherty, 2000).

II. Consultant Contracts

- A. Many problems can be avoided by establishing a clear, written contractual agreement between the consultant and the consultee that clarifies the type of relationship that will be established.
- B. The following are recommendations for consultant contracts (Remley & Herlihy, 2001; Remley, 1993):
 - Clearly specify the work required
 - Describe in detail any work products expected
 - Establish a time frame
 - Describe the compensation plan and method of payment
 - Specify any special agreements or contingency plans

III. Internal vs. External Consultants

- A. The relationship of consultant to consultee can be further complicated by the fact that consultants may be performing:
 1. Internal consultation – In larger organizations, a consultant may be a full-time employee of the organization (internal consultant).
 2. External consultation – In contrast, an external consultant is hired from outside of the organization (external consultant).
- B. While significant differences do exist between internal and external consulting, most of the principles and processes remain the same (Kurpius & Fuqua, 1993).
 1. Internal consultants
 - Internal consultants often have a personal investment in presenting the problems.
 - Internal consultants remain involved in the system after consultation is completed.
 - Internal consultants have an established image in the organization that may or may not be helpful.
 - In addition, internal consultants usually have extensive information about the organization that external consultants do not have.
 2. External consultants
 - External consultants are usually more easily seen as experts and require a greater financial commitment from the consultee.

RELATED KNOWLEDGE AND SKILLS

- In addition to knowledge and skills in (Zins, 1993) problem-solving, communication, and use of intervention techniques, additional specific knowledge and skill is needed for the ethical and the professional practice of consultation.
- These include, but are not limited to:
 - a. diagnosing
 - b. evaluating outcomes
 - c. understanding organizational culture and change

I. Diagnosing

- A. Diagnosis, a key process in organizational development, is an intervention designed to:
 - 1. Develop information about the subsystems, processes, and patterns of behavior within an organization
 - 2. Mobilize energy for change (Beer & Spector, 1993)
- B. A number of diagnostic approaches and techniques are addressed in the literature. Most emphasize three activities: (Beer & Spector, 1993).
 - 1. **Data collection** can be in the form of survey instruments, questionnaires, and interviews that measure such areas as job satisfaction, job perception, leadership, and group functioning (Beer & Spector, 1993; Cooper & O'Connor, 1993).
 - 2. The **discovery process** involves presenting the data collected to the group empowered to take action (i.e. administration) for analysis and strategic planning.
 - 3. **Feedback** involving the results of the discovery process and plan for action is sought from the rest of the organizational members (Beer & Spector, 1993).

II. Evaluating Outcomes

- A. Evaluation should help the consultant determine whether the desired result was achieved.
- B. While evaluation is typically identified as a distinct stage, usually toward the end of consultation, evaluation should be integrated with the consultation process (Kurpius, et al. 1993).
- C. Methods and measures of evaluation should be determined during the process of establishing goals, evaluating interventions and progress, and termination criteria (Kurpius, et al. 1993).
- D. Because the nature of consultation is triadic and systemic, evaluation should occur at the individual, dyadic, and systemic levels (Dixon & Dixon, 1993).
- E. An ethical issue, related to evaluation, is the responsibility of the consultant to ensure that the services he/she provides are effective (Newman, 1993).

III. Understanding Organizational Culture and Change

A. Culture

1. Schein (1990) defined culture as
 - a pattern of basic assumptions,
 - invented, discovered, or developed by a given group,
 - as it learns to cope with its problems of external adaptation and internal integration,
 - that has worked well enough to be considered valid and, therefore,
 - is to be taught to new members as
 - the correct way to perceive, think, and feel in relation to those problems (p. 111).
2. Other definitions include values, mission, history, physical setting, myths, rites, symbols, etc. (Beer & Spector, 1993; Fuqua & Kurpius, 1993; Kuh & Hall, 1993).
3. Beer and Spector (1993) point out that culture looks backwards to what worked in the past and may create resistance to change in the present.
4. The consultant needs to explore carefully what aspects of the organizational culture are creating problems as well as what aspects are potential resources for further development of the organization.

B. Change

1. Organizations move through change cycles (Kurpius & Fugua, 1993):
 - development
 - maintenance
 - decline
 - crisis
2. The culture of an organization will influence how an organization responds to change at each stage. Some stages (decline and crisis) are more threatening than other stages. Likewise, the organization's capability to take advantage of change and development will be greater during other stages (Kurpius & Fuqua, 1993).
3. Understanding how culture and cycles impact the organization can help consultants and consultees explore their options.
4. The consultant will want to target both human behavior and the larger organizational structure (system) for change.
5. Addressing the overall system's functioning is often more manageable and effective than addressing changes in individual people.
6. "Philosophically, adapting organizational structure to meet the needs of people is a useful alternative to changing people to accommodate organizational structure" (Kurpius & Fuqua, 1993, p. 609).

ETHICAL AND LEGAL ISSUES

No code of ethics has been established especially for consultants. The ACA Code of Ethics contains two subsections (B.6 and D.2) that address consultation. Several ethical issues that consultants face have been identified (Doherty, 2000; Newman, 1993):

- a. values and culture
- b. competence
- c. consultee and client rights
- d. the consulting relationship

I. Values and Culture

A. Values

Conflict over value differences can raise a number of ethical concerns.

1. The consultants' values will influence the process and the outcome of their work.
2. Differences in worldviews, reasoning, communication patterns, and gender influences can contribute to conflict in the consultation process.
3. Values conflicts can occur at any stage of the consultation process. Therefore, consultants are urged to reflect carefully on their values in light of the goals of the organization to determine whether the consultants can support those goals (Corey, Corey, Callanan, 1998).
4. When an unanticipated value conflict occurs during the process of consultation, the issue should be addressed immediately and a decision made about whether or not to continue the consulting relationship.

B. Culture

The process of consultation may be affected also by the cultural context.

1. Differences should not be ignored but acknowledged, so that open, honest communication and mutual respect is fostered (Jackson & Hayes, 1993).
2. The consultant should become familiar with the culture of consultees.
3. Corey, Corey, and Callanan (1998) give the example that in Asian cultures consultants may be expected to assume a more directive role with consultees.

C. Values and Cultural Conflicts

1. While value and cultural conflicts can occur between a consultant and consultee, they are most likely to occur in organizational consulting where multiple parties are involved (Remley & Herlihy, 2001).
2. The consultant should refuse to negotiate a contract when he or she believes that value and cultural conflicts could impair his/her ability to help (Corey, Corey, Callanan, 1998).

II. Competence

- A. Consultants must have adequate training to perform the contracted services. In addition, they are expected to:
 - a. stay abreast of the field
 - b. perform only the services for which they are qualified
 - c. recognize their own limitations
 - d. avoid misrepresenting themselves
- B. Furthermore, consultants should be certain that the organization employing them has the needed resources to help clients and that referral resources are available (ACA Standard D.2.b).
- C. Consultants should not practice when personal issues (such as burnout, substance abuse, or others personal problems) would interfere or impair their services (Remley & Herlihy, 2001; Corey, Corey, Callanan, 1998).

III. Consultee and Client Rights

The nature of consultation is such that the client sometimes may not know that a consultant has been contracted or that multiple factors may be involved. Consultants must be aware of how their work will impact all parties involved so as to be sure that their services are not used to the detriment of anyone. Two crucial ethical issues are raised:

A. Informed Consent

Informed consent is an important right for both the consultee and the client.

1. In **peer consultation**, the issue is usually uncomplicated.
 - The consultee is expected to inform the client about the consultation and to obtain consent.
2. **Organizational consultation** often complicates the process of informed consent.
 - Administrators often hire consultants with little or no input by the employees. Employees may feel coerced to cooperate.
 - Consultants need to be aware of the hierarchical nature of organizations and to work carefully to make consent as informed and voluntary as possible (Welfel, 1998).
 - Goals, purposes, potential benefits and risks, and desired outcomes should be discussed with those who will be affected by the consultation (Dougherty, 2000).

B. Confidentiality

It is important that those who participate in the process of consultation have a clear understanding of the limits of confidentiality.

1. In **peer consulting**, confidentiality is usually straightforward because it is easy for the consultee to keep the identity of the client hidden.
2. In **organizational consulting**, however, dealing with the issue of confidentiality is more difficult.
 - For example, if the consultation is aimed at making organizational changes, how comfortable will disgruntled employees be in sharing honestly with the consultant? (Remley & Herlihy, 2001; Newman, 1993)
 - Dougherty (2000) suggests using procedures to insure anonymity of information; the consultant should deal with questions of confidentiality at the outset and come to a consensus on confidentiality limits and maintenance.

IV. The Consulting Relationship

A. Ethical Issue – The Consultant’s Motivation

- An additional ethical issue is the motivation of the consultant. Creating a market niche for oneself by failing to help people acquire skills and greater independence is an ethical pitfall (Corey, Corey, Callanan, 1998; Wubbolding, 1991).

B. Legal Issues – Contract Law

1. A number of legal pitfalls exist for the consultant as well.
2. Most of these relate to contract law.
3. Consultation arrangements can range from a vague agreement to a short conversation to formal written contracts.
4. Contracts do not have to be written to be binding. From a legal perspective, a contract exists when three elements are present:
 - a. **An offer** is a proposal to enter into an agreement.
 - b. **Acceptance** occurs when the person to whom the offer is made agrees to the offer.
 - c. **Consideration** occurs when something of value (usually money, but it could be intangible items of value as well) is given by the person making the offer to the one who receives the offer.
5. Remley (1993) warns that the consultant should avoid using overly optimistic language or making any implication of a guarantee of outcomes. Even an implied guarantee of outcomes can make the consultant vulnerable to a breach-of-contract charge (contract law).
6. In addition, a consultee who is harmed by a consultant under contract can file suit for damages under tort law, which can include charges for negligence, malpractice, and defamation (McCarthy & Sorenson, 1993).

C. Contracts – External Consultation vs. Internal Consultation

1. Consultation contracts are usually a greater issue for external consultants.
2. In the case of internal consultants, since the same employer pays all of the parties involved, consideration does not exist. Consideration must be present for a contract to be established. A legally binding contract is usually not established with an internal consultant.

D. Written Contracts

1. Because of the danger of misunderstanding, consultation contracts should be written and should be done so only after the consultant and consultee have had a thorough discussion of the situation.
2. The following are guidelines for written contracts:
 - All pages should be numbered.
 - Names should be legibly printed and signed.
 - The date of the signatures should be included.
 - Any changes should be initialed by both parties.
 - Two copies of the document should be signed so that each party can keep an original (Remley, 1993).

Chapter 8

Group Dynamics, Theories, & Techniques

GROUP DYNAMICS, THEORIES, AND TECHNIQUES

NCE – Chapter 8

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GROUP DYNAMICS, THEORIES, AND TECHNIQUES

NCE – Chapter 8

HISTORY OF GROUP WORK

I. Significant People and Occurrences in the History of Group Work

- 1920s
 - Adler performed individual counseling in a group setting; he brought the concept to the U.S. in 1925.
 - Jacob Moreno observed a curative effect in individuals in theatrical productions.
- 1931 Jacob Moreno coined the term “group counseling.”
- 1936 Jacob Moreno coined the term “group psychotherapy.”
- 1940s Two organizations for group counseling were formed:
 - American Society for Group Psychotherapy and Psychodrama
 - American Group Psychotherapy Association
- 1940s The severe psychological problems brought on by and during World War II taxed the availability of counselors for individual counseling. The shortage sparked an increase in the use of group counseling.
- 1960s Counseling groups became accepted; previously most counseling was dyadic (of 2).
- 1973 Association for Specialists in Group Work (ASGW) was formed as a division of the American Counseling Association (ACA) and published *The Journal for Specialists in Group Work*, the ASGW journal.

II. The Association for Specialists in Group Work

The Association for Specialists in Group Work (ASGW) promulgates professional training and practice of group work. ASGW establishes ethical standards, supports research, and seeks to provide professional leadership in the field of group work. ASGW has published *Professional Standards for the Training of Group Workers* (January 22, 2000), *Association for Specialists in Group Work Best Practice Guidelines* (March 29, 1998), and *Principles for Diversity-Competent Group Workers* (August 1, 1998).

III. Group Work Defined

Group Work is defined by ASGW as “a broad professional practice involving the application of knowledge and skill in group facilitation to assist an interdependent collection of people to reach their mutual goals which may be intrapersonal, interpersonal, or work-related. The goals of the group may include the accomplishment of tasks related to work, education, personal development, personal and interpersonal problem solving, or remediation of mental and emotional disorders” (ASGW, 2000).

GROUP DYNAMICS – BEST PRACTICES

The ASGW Standards for the Training of Group Workers and CACREP standards agree that all counselors should possess a set of core competencies in general group work. These core competencies encompass both a theoretical and experiential understanding of group processes and communication, of ethical and legal considerations, and of the impact of theoretical models or orientations.

The ASGW Best Practice Guidelines are summarized here. They are “intended to clarify the application of the ACA Code of Ethics and Standards of Practice to the field of group work” (ASGW, 1998). Group workers “must give attention to the intent and content of their actions because the attempts of Group Workers to influence human behavior through group work always have ethical implications” (ASGW, 1998).

The ASGW Best Practice Guidelines address Group Workers’ responsibilities in planning, performing, and processing groups (ASGW, 1998). The counselor must take the following issues into consideration.

I. Planning

A. Professional and Regulatory Requirements

The group counselor will meet:

1. All applicable ethical codes
2. Standards of best practice
3. Training standards
4. Diversity guidelines
5. State laws
6. Accreditation requirements
7. Insurance requirements

B. Scope of Practice and Conceptual Framework

Group workers evaluate their personal training level, strengths, weaknesses, and conceptual orientation and only perform group work within this framework.

C. Assessment of Self

The counselor’s own values, beliefs, and theoretical orientation and his/her impact on the group will be evaluated.

D. Ecological Assessment

The group counselor will assess:

1. Community needs
2. Agency or organization resources
3. Sponsoring organization mission
4. Staff competency
5. Attitudes regarding group work
6. Multicultural and diversity considerations

E. Program Development and Evaluation

1. Identification of types of groups to be offered and their relationship to community needs
2. Stating in writing the purpose and goals of the group and the role of the group members in influencing and determining these goals
3. Setting fees consistent with the sponsoring organization and the financial status and locality of prospective group members
4. Choosing a leadership style and techniques appropriate with the type of group offered
5. Formulating and implementing an evaluation plan
6. Using technology appropriately

F. Resources

1. Coordination of adequate funding
2. Appropriateness and availability of a trained co-leader
3. Space requirements for type of group
4. Privacy requirements for type of group
5. Type of marketing and/or recruiting strategy needed
6. Appropriateness and availability of collaboration with other organizations

G. Disclosure

A professional disclosure statement which gives the client information about the following items is required:

1. Confidentiality
2. Exceptions to confidentiality
3. The counselor's theoretical orientation
4. The nature, purposes(s) and goals of the group
5. Group services that can be provided
6. Role and responsibility of group members
7. Role and responsibility of the group leader
8. The leader's qualifications to conduct this type of group
9. The leader's licenses, certifications, and professional affiliations
10. Addresses of the appropriate licensing or credentialing bodies

H. Group and Member Preparation

1. Potential group members will be screened.
2. Members will be chosen based on having compatible needs and goals with the group.
3. Informed consent will be provided in oral and written form (when appropriate to group type) and will include the following:
 - a. The professional disclosure statement
 - b. Group purpose and goals
 - c. Group participation expectations including voluntary and involuntary membership
 - d. Role expectations of members
 - e. Role expectations of leaders
 - f. Policies regarding entering and exiting the group
 - g. Substance use policies
 - h. Policies and procedures governing mandated groups (as relevant)
 - i. Documentation requirements
 - j. Policies regarding disclosure of information to others
 - k. Implications of out-of-group contact or involvement among members
 - l. Procedures for consultation between group leader(s) and group member(s)
 - m. Fees and time parameters
 - n. Potential impacts of group participation
4. Appropriate consent forms for dealing with minors and other dependents are obtained.
5. Confidentiality is defined along with its limits, i.e. ethical or legal expectations or exceptions, waivers required with certain treatment plans and insurance usage, etc.
6. All group members are informed of the need for confidentiality, of potential consequences of breaching confidentiality, and of the lack of legal privilege extended to group discussions except where provided by state statute.

I. Professional Development

1. Knowledge and skill competencies are kept current and increased.
2. Ethical concerns that interfere with effective group leadership are submitted to consultation or supervision.
3. Supervisors maintain current knowledge and skills regarding consultation, group theory, process, and ethical guidelines.
4. Professional assistance is sought for a leader's personal problems or conflicts that impair or are likely to impair professional group leader functioning.
5. Any lack in knowledge or skill competencies for leading a particular type of group are submitted to consultation or supervision.
6. A group leader stays abreast of currently accepted group practices, research and development.

J. Trends and Technological Changes

A group worker is aware of and responds to technological changes as they affect society and the counseling profession. Current considerations are changes in mental health delivery systems, legislative reforms, insurance industry reforms, demographic shifts, and internet use and other communication and delivery systems. Ethical guidelines are followed.

II. Performing

A. Self Knowledge

A group worker knows his or her own strengths and weaknesses and the impact of these on group members.

B. Group Competencies

1. A group leader is knowledgeable of group dynamics.
2. A group leader is able to perform the core group competencies.
3. A group leader possesses adequate understanding and skill of any group specialty area chosen.

C. Group Plan Adaptation

1. Knowledge, skills, and techniques are modified and applied as is appropriate for the particular group's type, stage, member make-up, etc.
2. Progress toward the group's goals and plan are monitored.
3. Ethical, professional, and social relationship boundaries are defined and maintained.

D. Therapeutic Conditions and Dynamics

Appropriate models of group development, process observation, and therapeutic conditions are understood and implemented.

E. Meaning

A group leader assists members in generating meaning from the group experience.

F. Collaboration

1. A group leader assists members in developing individual goals.
2. A group leader respects members as co-equal partners in the group experience.

G. Evaluation

Evaluation, both formal and informal, is included between sessions and at the conclusion of the group.

H. Diversity

A group worker will be sensitive to client differences (ethnic, gender, maturity, economic, etc.).

I. Ethical Surveillance

1. Applicable ethical standards are employed (ACA, ASGW, other professional organizations, etc.)
2. Appropriate ethical decision making models are used in responding to ethical challenges and issues.

III. Group Processing

A. Processing Schedule

1. The workings of a group are processed by the group leader.
2. Processing may be done with co-leaders, the group members, supervisors, and/or other colleagues, as appropriate.
3. Processing may include assessing group or individual progress toward goals, leader techniques, leader behavior, group dynamics, interventions, and the development of meaning.
4. Processing may occur at any appropriate time: within sessions, before and after sessions, at termination of the group, as later follow-up, etc.

B. Reflective Practice

1. The group leader looks for and takes advantage of opportunities
 - a. to meld theory and practice
 - b. to incorporate learning outcomes into ongoing groups
2. The group leader attends to
 - a. session dynamics of members and their interactions
 - b. the relationship between session dynamics and the leader's values, cognition, and affect

C. Evaluation and Follow-up

1. Processes and outcomes are evaluated.
2. Conclusions from evaluation are applied to program planning, current groups, and/or professional research literature.
3. Follow-up contact with members is done, as appropriate, to assess outcomes or when requested by a group member(s).

D. Consultation and Training with Other Organizations

1. Group workers provide consultation and training, as appropriate, to organizations in and out of their setting.
2. Group workers will seek competent, knowledgeable consultation.

GROUP DYNAMICS – SPECIFIC TOPICS

While the ASGW Best Practice Guidelines provide an overview of required competencies, further elaboration in some areas is necessary.

I. Leadership Styles

A. Generalized Leadership Styles (Knowles, 1959)

The classic Lewin, Lippitt, and White study of 1939 identified three basic leadership styles and evaluated their effectiveness.

1. **Authoritarian** – The leader sees him/herself as an expert; very directive.
(Example: Psychoanalytic counseling; teaching)
 - Liked the least by members.
 - Members exhibit aggressive behavior; thirty percent higher hostility rate than with the other two styles.
 - Preferred when an immediate decision is necessary.
2. **Democratic** – Leadership is shared.
(Example: Group-centered counseling; non-directive counseling)
 - Members behaved appropriately.
 - Liked by members but not shown by research to be the most productive style.
3. **Laissez-faire** – No leadership is in place. This is considered to be generally ineffective.
(Example: New counselors and those who have a strong need to be liked.)
 - Members exhibit aggressive behavior.
 - Preferred when a decision has been made and committed to.

B. Yalom's Leadership Types (Yalom, 1985)

1. **Impersonals** – Are distant and aggressive. They rate low on caring. (Poor)
2. **Managers** – Use lots of structured activities and control how members interact. (Poor)
3. **Laissez-faires** – Provide low input, low support, and low control. (Poor)
4. **Social Engineers** – Are group-focused and concerned with how members relate to the social system. They rate low in charisma and low in emotional stimulation. (Moderate)
5. **Energizers** – Are caring and charismatic providing intense emotional stimulation and firm control. (Moderate)
6. **Providers** – Specialize in caring and meaning attribution. They focus on individuals and give love and information but don't press their own views on group members. (Best)

Note: The term “charismatic” (in the above descriptions) denotes a counselor using his or her own power of personality or attractiveness to encourage facilitation.

C. Group Leader Skills (Knowles, 1959; Corey, 1995)

Counselor attributes which improve and enrich individual counseling, such as genuineness (congruence, authenticity), will also enhance group counseling.

1. Active listening
2. Reflection and clarification
3. Questioning and summarizing
4. Information giving
5. Encouragement and support
6. Modeling
7. Self-disclosure at appropriate times
8. Blocking – intervention to stop counterproductive behaviors (scapegoating, group pressure, excessive questioning, etc.)
9. Attending behavior – evidenced by facing a group member who is talking, etc.

D. Leadership Functions (Knowles, 1959; Corey, 1995)

1. Screening of potential members
 - a. Recommended by ethical guidelines for all groups.
 - b. May be conducted individually or in the group setting.
 - c. Allows both client and counselor expectations and concerns to be expressed.
 - d. Allows client to evaluate leader's qualities and competence.
 - e. May engender trust in the client.
 - f. If done individually, may not evoke behavior that will be displayed in the group setting.
 - g. Remember:
 - i. Only appropriate members should be admitted.
 - ii. When individual counseling is being received by a potential member, the individual counselor should be contacted before admission is granted.
 - h. Several types of individuals have been identified by research as poor choices for group membership unless the group is specifically designed to deal with these particular issues:
 - hostile
 - physically aggressive
 - paranoid
 - actively suicidal
 - actively homicidal
 - psychotic (not in touch with reality)
 - totally self-centered
 - i. The most important member traits: the ability to trust; the ability to feel cohesive.
 - j. Members' traits correlated to premature termination from group included:
 - low intelligence
 - low motivation
 - high denial

2. Risk information and informed consent
 - a. Ethical guidelines require that risks of group membership be discussed during the screening interview or as soon as is possible thereafter.
 - b. Group confidentiality is desired but cannot be guaranteed.
 - c. The leader will attempt to reduce risks and dangers and will attempt to protect clients from risks.
 - d. Informed consent includes information regarding the stated purpose of the group, the qualifications of the leader, the potential risks involved (including negative outcomes), the rights of members to be treated with respect and dignity, the agreement to openly share concern's and to be open to the concerns of others, etc.
 - e. ASGW ethical guidelines state, "Group leaders shall inform members that participation is voluntary and they may exit the group at any time" (ASGW, 1998). If clients are in "mandatory treatment" (i.e., required by court order), clients should be told that appropriate notification will be made to the applicable authorities should the clients leave the group.
3. Emotional stimulation - Challenges, confronts, takes personal risks, self-discloses.
4. Caring - Offers support, affection, praise, protection, concern, and acceptance.
5. Meaning attribution - Explains, clarifies, interprets, and provides a cognitive framework.
6. Executive duties - Sets limits, rules, and goals; manages time, paces, and intercedes.

Experts report that a lack of goal setting is a weakness often found in group work and that if goals are defined they are often too vague to be effective.
7. Strategy and intervention variation
 - a. Should the counselor's approach be content or process oriented?
 - i. **Content** – the client's material; how the client is or seems.

"Jill seems relaxed." "I hear hurt in George's voice."
 - ii. **Process** – how communication happens or transpires; how the client acts.

"Bill looks away or Rachel closes up when something is mentioned."
 - b. Should the counselor's approach be **horizontal** or **vertical**?
 - i. **Horizontal** – the leader works with the group as a whole and employs techniques which facilitate group processes, tasks, interactions, and relationships; sometimes called interpersonal. Interpersonal leaders tend toward here and now interventions.
 - ii. **Vertical** – the leader works with individuals within the group and, in effect, provides individual counseling in a group setting; sometimes called intrapersonal. Intrapersonal leaders tend to focus on the past and sometimes use psychodynamic principles.

Effective counseling will exhibit both horizontal and vertical interventions.

E. Leader Training

Experts in group work such as Marianne Schneider Corey, her husband Gerald, and Irvin Yalom agree that additional training in group leadership is necessary (more than the course on group work in most graduate programs). Such training could include:

1. Participation in a group for leaders where the focus is leadership skills.
2. Participation in a personal counseling group so that any of the leader's issues that might lead to countertransference can be dealt with.

II. Group Developmental Stages

Just as Erik Erikson proposed a series of psychosocial crises to explain human growth and development, the life cycle of a group relies on the effective completion of the previous stage.

Most group development theorists propose from three to seven stages, and they have labeled the individual stages of group development many ways. There seems to be a general consensus, however, that there are major tasks associated with a pattern of moving from initial orientation to transition to working to termination.

Keep in mind that these stages overlap, and even regression from a higher level will occur at times. The usefulness of interventions should be based on the counselor's understanding of these tasks and the general order in which they occur.

Associate the theorist's name with their model and have a thorough understanding of the general order that occurs, the terms associated generally with each stage, and the general characteristics of each stage.

A. Specific Developmental Group Stages Proposed by Theorists

1. Yalom (1995)
 - a. Orientation
 - b. Conflict
 - c. Cohesion (in two levels)
 - great mutual support – the group against the world.
 - true teamwork – each member against his or her own resistances.
2. Tuckman & Jensen (Tuckman & Jensen, 1965)
 - a. **Forming**/Orientation (Acceptance, approval, commitment, search for orientation and structure)
 - b. **Storming**/Transition (Dominance, control, power)
 - c. **Norming** (Risk taking, openness, cohesiveness, caring)
 - d. **Performing**/Working (Honesty, spontaneity, responsibility, self-disclosure)
 - e. **Adjourning** (Terminating, distancing, summation, closure)
3. Schutz (1973)
 - a. **Inclusion** – Members strive to be accepted and loved by the leader.
 - b. **Power** – Members attempt to gain autonomy from the leader.
 - c. **Affection** – Members look to one another for aid both in giving and in receiving help.

4. Gazda (2001)
 - a. Exploratory Stage – superficial
 - b. Transition Stage – significantly deeper self-disclosure
 - c. Action Stage – working, productive
 - d. Termination Stage – tapering off of self-disclosure

5. Corey and Corey (2000)
 - Stage 1: Pregroup Issues – Formation of the Group
 - Stage 2: Initial Stage – Orientation and Exploration
 - Stage 3: Transition Stage – Dealing with Resistance
 - Stage 4: Working Stage – Cohesion and Productivity
 - Stage 5: Final Stage – Consolidation and Termination
 - Stage 6: Postgroup Issues – Follow-Up and Evaluation

B. Characteristics of Group Developmental Stages

1. Introduction - Initial - Orientation - Exploration - Forming Stage

Inclusion, identity, trust, and establishment of goals are the issues.

- a. Self-disclosure
- b. Setting structure of the group meeting
- c. Setting norms
- d. Getting acquainted based on externals (dress, language, culture, occupation)
- e. Clarifying expectations
- f. Defining individual goals
- g. Leader responses: warmth, empathy, respect for members
- h. Characterized by approach-avoidance conflicts
- i. Employing techniques specifically chosen to
 - Initiate getting acquainted
 - Focus members
 - Create trust
 - Deal with initial resistance and fears
 - Start a session
 - Ending a session
 - Teach member self-evaluation

2. Transition - Power and Control - Storming Stage

Anxiety, defenses, resistance, and ways to address the goals are the issues.

- a. Vying for position or power
- b. Exhibiting resistance or judgmentalism
- c. Verbally attacking the leader and other members
- d. Fighting among subgroups and factions
- e. Leaders must learn to distinguish between a “challenge” and an “attack” (Corey and Corey, 2000)
- f. Leader responses: genuineness, concreteness, deeper self-disclosure
- g. Employing techniques specifically chosen to
 - Deal with defensive behaviors
 - Deal with difficult members
 - Deal with conflict
 - Explore common fears and resistance
 - Deal with challenges to the leader

3. **Working - Action - Productive Stage**

Taking responsibility for attaining goals and changing behaviors are the issues.

- a. Increasing cohesion and trust to a high level
- b. Increasing mutuality and self-exploration
- c. Less dependence on the leader
- d. Modifying interaction patterns
- e. Committing to change in the here-and-now context
- f. Leader responses: interpreting meaning, appropriate confrontation, and feedback
- g. Employing techniques specifically chosen to
 - Deal with expressed confusion
 - Deal with issues of closeness
 - Teach appropriate disclosure
 - Elicit emotional responses when they are being held back
 - Deal with the fear of losing control
 - Deal with intense emotions in all members simultaneously
 - Work with dreams
 - Work with projection and self-awareness problems

4. Termination - Separation - Adjourning Stage

Reinforcing the growth experienced by members, making sure differences between members are worked out before departure, and assisting with ongoing individual counseling as needed are the issues.

- a. Summarizing the group's activity and discussion
- b. Evaluating the group process
- c. Allowing the group to evaluate the group and themselves individually
- d. Providing for referral or continued counseling for those who feel they should continue
- e. Explaining that because of emotional involvement it may be strange to not have group and there may be a period of adjustment; outside bonds should be established
- f. Saying good-bye
- g. Employing techniques specifically chosen to
 - End a session
 - Terminate a group
 - Assess and follow-up
 - Evaluate a group

NOTE: Regarding structured vs. unstructured techniques through the stages of group development – Yalom (1995), in particular, warns that unstructured techniques/exercises are more effective than structured ones in achieving the desired results at each stage.

Too much structure:

1. Interferes with group stage development as stages sometimes are skipped.
2. Causes members' feelings to be purged before the members are properly prepared.
3. Can make the members dependent on the leader for direction.
4. Produces lower outcome results.

Group exercises must be matched to the group developmental stage. For example, orientation is a time for trust-building exercises; transition is a time for techniques exploring resistance, etc.

III. Group Structure

A. The Word “Structure”

The word structure is used in the field of group work in three contexts.

1. Structure can refer to **the basic format or formulation of the group**, i.e. an adult group, a heterogeneous group, a closed group, etc. (often referred to as the group structure).
2. Structure can refer to **the use of (or absence of) structured exercises or tasks given by the leader to the group**, i.e. “Today we will answer this question...” (often referred to as structuring the group). Note that behavioral groups employ many specific exercises and are, therefore, generally highly structured. Existential groups, nondirective groups, and psychodynamic groups, on the other hand, generally employ few directive techniques and have few concrete treatment objectives. They are, therefore, considered less structured. Since a group must have some structure to even exist, the term “unstructured” would imply a group with a very low degree of structure.
3. Structure can refer to a **group focused on a particular theme or topic**, such as a group for single parents, assertiveness training, etc. (often called a structured group).

B. Suggestions for Group Structure (Yalom, 1985; Corey, 1995)

1. **Adult Groups:** Adult groups have been successful with as few as three members and as many as fifteen. Groups usually have between 8 to 10 members with the optimum size for adult groups being **eight**. Research indicates that as the group increases in size, opinions and personal sharing decreases, and the group becomes more leader centered.
 - The groups generally meet once a week for one or two hours with the average being ninety minutes. Most counselors consider **heterogeneous** groups best to stimulate maximum interaction. Heterogeneous groups include socio-economic, illness, and behavioral pattern categories.
2. **Adolescent Groups:** Adolescents do well in **groups with their peers**, especially for exploring their outlook on authority, peer pressure, social development, and consolidation of their identity. Group size can range between 6 to 8 members; the optimum size is **six**.
 - Role playing techniques are useful in helping an adolescent see someone else's point of view.
 - "Promises" of confidentiality must allow that child abuse, sexual abuse, neglect, and exploitation be reported. Additionally, ethics would require the same for suicidal adolescents and for those planning to harm someone else.
3. **Children's Groups:** Younger children are usually placed in small groups of two or more but never over five; the optimum size is **three or four**. Children are best served in groups of children **their own age but with somewhat diverse problems**. The length of sessions depends on the children's attention span with more frequent, shorter sessions often recommended. Ginott recommends play therapy for children ages 3-9 years old. Dinkmeyer and others suggest using a variety of media.
 - Corey and Corey believe that reducing resistance and improving cooperation with children is best gained by enlisting parental involvement. The counselor should not side with a child against a parent or an institution.
 - Role playing techniques are useful in helping children see someone else's point of view.
 - "Promises" of confidentiality must allow that child abuse, sexual abuse, neglect, and exploitation be reported. Additionally, ethics would require the same for suicidal children and for those planning to harm someone else.

C. Closed vs. Open Groups

1. Closed Groups

- No new members are allowed to join after start date.
- Promotes cohesiveness and trust since membership is consistent.
- Drop in membership may cut the overall interaction of members.

2. Open Groups

- New members are allowed to join after the start date.
- Cost effective since new people may replace those that drop.
- Members joining after the first session do not receive information/experiences shared earlier.

D. Homogeneous vs. Heterogeneous Groups

1. Homogeneous

Members are similar or alike; have similar problems (alcoholic, weight).

Advantage – Homogeneity promotes cohesiveness.

2. Heterogeneous

Members are dissimilar or not alike; problems are different (general counseling groups with members from differing backgrounds and with varying problems).

Advantage – Heterogeneity more nearly replicates the real world and allows clients to learn from others.

Note: Group members will migrate toward (sit by, talk to, etc.) similar group members or members with whom they feel they have something in common.

IV. Member Roles and Behavior

A. Norms

Norms are the rules, whether spoken or unspoken, that tell individuals how to act in the group. All groups have norms, meaning that there are expectations of behavior within the group even if these guidelines are not formally laid out. Norms will vary depending on the type of group and the role of the member in the group.

B. Roles

Within the group, members play roles which help with focusing the group, setting goals, and solving problems. These are generally classified as:

1. task roles (positive) – help the group carry out a task
2. maintenance roles (positive) – help maintain and strengthen processes of the group
3. self-serving/individual roles (negative) – intent on meeting own needs at expense of the group; work against the group

C. Group Building and Maintenance Roles: That Which Helps Hold a Group Together (Ohlsen et al., 1988; Corey, 1995)

1. Facilitator/Encourager – Encourages, extends friendship, and offers security
2. Gatekeeper/Expeditor – Acts as the counselor's assistant and keeps members within group norms; may avoid working on own issues; may secretly want to lead the group
3. Standard or Goal Setter – Pushes for goal definition
4. Harmonizer/Conciliator – Mediates mostly emotional or feeling issues
5. Compromiser/Neutralizer – Mediates mostly cognitive alternatives
6. Observer – Gives feedback but does not participate in depth
7. Follower/Neuter – Bends with the wind and doesn't really participate

D. Group Task Roles: That Which Helps a Group Get the Job Done

1. Energizer/Initiator – Prods for action; generates enthusiasm
2. Information/Opinion Seeker – Pushes for clarification
3. Information/Opinion Giver – Adds facts, makes suggestions, and shares ideas
4. Elaborator/Coordinator – Furnishes the reality orientation for the group
5. Orienteer/Evaluator – Judges and focuses on the task at hand
6. Procedural Technician – Is similar to the gatekeeper but focuses on mechanics and procedure

E. Negative and/or Destructive (Anti-Group) Task Roles

Anti-group behaviors are many and varied and include the following:

1. Scapegoat – a member who is the object of accusations and blame by other members
2. Interrogator – constantly asks questions
4. Peeping Tom – asks other members inappropriate questions
5. Storyteller – takes up valuable time telling long, often irrelevant, stories
6. Joker – uses jokes as smoke screens or to belittle others or self
7. Isolate – are genuinely rejected and ignored; are given little or no attention

F. Other Group Behavior Considerations

1. **Risky Shift Phenomenon** – Research shows that the individual will shift toward the social norm. In simple terms, an individual will tend to go along with the group. His or her decision will be more liberal when made with the group than if the decision had been made before the individual met with the group.
2. Some theorists believe that the **roles** people play in groups are **mirrored from** their roles in their **nuclear families** and can be explored on that basis.
3. Since needs of group members change, **the roles group members fill should change** to meet these needs. The capacity to be flexible and change roles indicates a healthy group. A group stuck in task roles will experience lower levels of interaction; a group stuck in maintenance roles will accomplish low levels of work or tasks.
4. **Role conflict** denotes a discrepancy between a member's expected behavior and his or her actual behavior.
5. **Conflict of interest** denotes a group member meeting his or her need instead of the group's need.

V. Therapeutic Factors and Forces

A. Curative Factors, according to Irvin Yalom, that make up the process of therapeutic change are the following (Yalom, 1985):

1. **Installation of hope** – Hope is the necessary element which allows the client to believe that a change will occur through counseling. Clients need to believe in the benefits of counseling; the degree of expectation of change will usually correlate with encountering positive effects from counseling.
2. **Universality** – Universality refers to the realization that the client has problems that are similar to those of other people. A client will begin counseling feeling that his/her problems are unique. He/she will feel enormous relief when he/she learns that "I'm not alone."
3. **Imparting of information** – The imparting of information takes place as the client learns of different elements involved in the process of psychotherapy. A client will learn a great deal about the group process by experiencing it. His/her knowledge may not be formulated explicitly, but in general terminology, he/she would be able to discuss the process knowingly.
4. **Altruism** – Altruism is effected as each member of the group comes to see him/herself as important to the group. Some members tend to see the counselor as a "paid" group leader and will listen more readily to another group member. As the counselor conveys the idea that each member is important and is potentially important to the other members, each member gets an ego boost.
5. **The corrective recapitulation of the primary family group** – A group bears a resemblance to a family, and as such, it contains family patterns and serves as a vehicle for group members to resolve past or present family-related issues. Ways of interacting with family members can be "tested" in the group for their effectiveness.
6. **Development of socializing techniques** – The group can affect the way we act and function socially. In group, there is appropriate and inappropriate behavior just like in society. In group, a person can deal with his/her problems constructively and enhance his/her social skills in the process.
7. **Imitative behavior** – Members may copy the behavior of the group leader or other group members. This can be effective because a member sees a model to follow, and this makes him/her realize what elements of another person can be tried in his/her own life.

- 8.* Interpersonal learning** – Through the group process a member will become very aware of the different aspects of self. The individual will interact in group and give clues of what he/she is and where he/she is going to the other members. This can be discussed and the learning process will begin.

Steps of interpersonal learning:

- a. Members exhibit disturbed behavior.
 - b. The group becomes a social microcosm, a representation of each member's universe.
 - c. Members become self-aware through other members' feedback and self-observation. Members witness their own behavior and come to appreciate the impact their behavior has on three things: the feelings of others, the opinions that others have of them, and the opinions they have of themselves.
 - d. Awareness of this sequence makes the member personally responsible for it. "Each individual is the author of his or her own interpersonal world."
 - e. Accepting responsibility means that if they created their social-relational world, then they have the power to change it.
- 9.* Group cohesiveness** – The group members, including the group leader, will form relationships with each other. This unity provides an atmosphere of free expression, the freedom to remain silent, and the facilitation of change.
10. **Catharsis** – Affording expression of those feelings inside of a person acts as a catharsis for the person. Only if the client is willing to express these feelings can change result and/or can interaction take place.
11. **Existential factors** – Life presents issues that we all are going to face. The client has to be aware that there will be pain, death, etc., and the counselor or group leader can't change these facts of life. These factors have to be incorporated into counseling to help the person deal with and cope with these issues.

***Note: Numbers 8 & 9 are the most important and complex according to Yalom.**

Gerald Corey and others have observed that these factors are easily integrated into various theoretical frameworks and are, therefore, very useful in most group settings.

B. Cohesiveness

Group cohesiveness or group unity denotes the sense of caring one has for the group and for other members of the group. Kurt Lewin (field theory) viewed cohesiveness as the binding force among group members and called it “positive valence.”

As cohesiveness strengthens, negative factors and behaviors such as absenteeism are lessened, group productivity increases, and commitment strengthens. A group with low cohesion is “fragmented.”

C. Therapeutic Forces within a Group (Ohlsen, 1988)

1. Attractiveness of the group
2. Acceptance by the group
3. Expectations of the client by the group
4. Sense of belonging
5. Therapeutic tension
6. Therapeutic norms
7. Client participation
8. Client acceptance of responsibility for his/her own growth
9. Feeling of security
10. Commitment to openness and risk-taking
11. Congruence between members
12. Feedback

D. Yalom's Reasons for Dropouts (1985)

1. External factors
2. Group deviance (the person is not a good fit)
3. Inadequate orientation
4. Subgrouping (cliquing)
5. Problems with intimacy
6. Fear of emotional contagion
7. Inability to share the counselor
8. Early provocation by the group
9. Competition of individual versus the group process

VI. Assessing Group Outcomes/Results

A. Member-Specific Measures

1. Measure change (or lack of change) in individual members.
2. Include self-ratings and ratings by outside observers.
3. Are not standardized.

B. Group-Specific Measures

1. Measure change (or lack of change) in all members of the group.
2. May include follow-up sessions in which group members share experiences.

C. Global Measures

1. Utilize projective measures in a pre-test and post-test format.
2. Will probably assess changes in areas not addressed in the group.

Note that critics propose the use of more independent observers to validate group counseling results (i.e., having unrelated observers sit in during group sessions to rate behavioral change).

VII. Advantages and Disadvantages of Groups

A. Advantages of Group Counseling over Individual Counseling (Corey, 1995; Gazda, 2001)

Group counseling provides:

1. Reality testing of one's self-perception.
2. The desensitizing of a distorted self-image.
3. Psychological safety to support the elimination of self-defeating behavior.
4. "In-vivo"/real life situations in which a person may try new behaviors.
5. An awareness of universality; an "I'm not alone" reality is conceived.
6. The practicing of giving and getting feedback and self-disclosure.
7. The enhancement of one's empathy and social interest.
8. Over time, the making of changes and the receiving of reinforcement.
9. Deeper understanding and acceptance of individual differences.
10. Feedback from both group members and the counselor to enhance one's accuracy in perception and communication.
11. Modeling as members observe other members dealing with problems.
12. The ability to see more clients in the same amount of time.
13. Less expensive and less time-consuming help.

B. Disadvantages and Limitations of Group Counseling

1. Each member receives less attention than that received in individual counseling, particularly if the leader is process rather than content oriented.
2. Group counseling has less situational control.
3. Confidentiality is more difficult to maintain.
4. **The danger of "group think," the forcing of a group opinion on all members, is present.**
5. A shared reality may replace one's individual reality.
6. A group leader must make many more decisions than an individual counselor makes.
7. **Scapegoating must be guarded against.**
8. Group members could experience emotional harm if the leader loses control.
9. Clients may benefit more from group counseling after receiving some individual counseling.
10. Group counseling is not initially applicable to clients in crisis, clients needing testing interpretation, clients who are phobic regarding speaking in public, or clients needing strict confidentiality.

VIII. Classification of Groups

Group process theorists often classify groups.

One model is Gerald Caplan's **Crisis Intervention Model**:

- A. Primary groups – preventive; teach coping strategies or life-style characteristics that can reduce the incidence of a problem (ex. diet and weight management to prevent diabetes).
- B. Secondary groups – attempt to reduce the severity or the length of time of disturbing behaviors; a problem is present but is not usually severe (ex. grief group).
- C. Tertiary groups – deal with severe, longstanding problems or disturbances; has more of an individual focus.

Guidance, counseling, and counseling groups can be described using Caplan's model:

- A. Guidance groups – primary (preventative) groups; sometimes called **affective education** groups or **psychological education** groups; do not deal with remediation; leadership requires little training.
- B. Counseling groups – secondary; focused on conscious issues; not likely psychodynamic; leadership requires some training.
- C. Therapy groups – tertiary; the psychological disturbance is rather severe and will require a longer term of individual work; deals with remediation of more severe pathology; may be psychodynamic; leadership requires much training.

IX. Types of Groups Requiring Specialized Training

Four kinds of group work are delineated by ASGW as requiring advanced leadership skills:

A. Task and Work Groups – focus on leading groups in correcting or developing their organizational functioning; may include facilitating planning or evaluation.

1. Leader role
 - Facilitator
2. Techniques
 - standard discussion methods
 - team building
 - collaborative group problem solving
 - consultation regarding program development
 - strategies to effect change
3. Required contextual understanding
 - Organizational, community, and/or political dynamics since task groups often occur within these settings.
4. Related required components
 - a. maintaining task/work group focus
 - b. maintaining relationship with the larger organization of which the task/work group is a part
 - c. clear goal setting and measurement
 - d. clearly defined decision-making options
 - e. preparing the group to expect conflict, to recognize it, and to constructively deal with it
 - f. observing task/work group processes including group climate, membership, norms, task maintenance, feelings, participation levels, decision-making, individual influence, etc.
 - g. quality feedback

B. Psychoeducation Groups – focus on particular themes chosen from needs assessments or relevant literature; impart information and provide education and support.

1. Leader role
 - Instructor; facilitate skill development.
2. Techniques
 - Structured or semi-structured group facilitation
 - Each session is structured and exercises within the sessions are structured.
3. Required contextual understanding
 - a. Often focused on prevention (primary prevention is intervention intended to lessen new occurrences of behavior); group activities change with the degree of “at-risk” potential of members.
 - b. Comprehension and application of human lifespan development with accompanying diversity, environmental, demographic, social marketing, and system development influence issues.
4. Related required components
 - a. Systematic, clear, organized relaying of information.
 - b. Interrelated goals, strategies, activities, methods, delivery, and evaluation.
 - c. Psychoeducation group leader skills include
 - i. Knowledge of, research in, and concepts of content area.
 - ii. Ability to select and recruit appropriate members, especially with “at risk” populations.
 - iii. Competence in designing appropriate structured sessions and exercises.
 - iv. Awareness and monitoring of structure to prevent “information overload.”
 - v. Self-perception and choice-making leads to empowerment of members.
 - vi. Ethical considerations include:
 - Attending to individual needs of members.
 - Avoiding invasion of privacy in “healthy,” low-risk members.

C. Group Counseling – focuses on enhancing growth and self-awareness and removing blockages to growth.

1. Leader role

- Role characteristics will depend on the leader's personal conceptual framework (cognitive, existential, behavioral, etc.) and the group situation.
- Co-leadership or co-facilitation may be employed:
 - a. Provides additional role model for group members.
 - b. Provides support and safety for leaders.
 - c. Guards against burnout.
 - d. Facilitates the leaders' processing the group experience and evaluation; best if leaders meet both before and after each session.
 - e. Requires a good match between leaders.
 - f. Requires an on-going working relationship between leaders that is open and sharing; not questioning the other's competence; not working against each other; not in a power struggle.
 - g. Allows stronger focus on group dynamics.
 - h. Allows group to meet if one leader is absent.
 - i. Provides additional feedback to group members.
 - j. Allows effective communication to be modeled.
 - k. Allows effective leadership to continue even when one leader is experiencing countertransference.
 - l. Allows novices to learn to lead a group.

Note: A male/female co-leading team is considered especially advantageous.

2. Techniques

- a. Chosen based on leader's conceptual framework.
- b. May include self-disclosure, feedback, modeling, skills training, confrontation, assigned homework, viewing videos, journaling, role playing, etc.

3. Required contextual understanding

- Potential group members must be matched with other members and the group as a whole to facilitate a successful group experience. Goals, expectations, levels of functioning, availability, and motivation are all factors.

4. Related required components

- a. Counseling group leader skills include:
 - i. Knowledge of and the ability to make referrals as necessary.
 - ii. Knowledge of group processes, therapeutic factors, and feedback and self-disclosure behaviors.
 - iii. Ability to assess interpersonal phenomena including engaging others, inclusion, openness, and control.
 - iv. Assessing similarities and differences between stated beliefs and actual behaviors.
 - v. Assigning reasonable meanings to nonverbal and culturally related behaviors.
 - vi. Recognizing self-defeating behaviors.
 - vii. Employing interventions appropriate for the group and the individual member's developmental stages.
 - viii. Effectively responding to conflict within the group and to excessive or inappropriate behavior.
- b. Members must learn to apply learning from the group experience to everyday lives.
- c. Informed consent must be obtained during the formation process.
- d. Evaluation of group progress, effectiveness, and value is conducted by the leader's collecting relevant data (pre- and post-test methods, during sessions, at end of sessions).

5. **Advantages** of group counseling

- a. Benefit of interpersonal relationships and interpersonal learning.
- b. Less expensive than individual counseling.
- c. Therapeutic orientation.
- d. Provides automatic support group.
- e. Allows learning of problem-solving strategies.

6. **Disadvantages** of group counseling

- a. Difficulty in recruiting and appropriately matching members to a group.
- b. Individual needs may not be addressed.
- c. Client confidentiality is difficult to maintain.

D. Group Psychotherapy – focuses on remediation, treatment and personality reconstruction.

1. Leader role

- Role characteristics will depend on the leader's personal conceptual framework (cognitive, existential, behavioral, etc.) and the group situation.

2. Techniques

a. Chosen based on leader's conceptual framework.

b. May include:

- interpersonal and intrapersonal assessment
- diagnosis
- interpretation
- linking current problems with client's history, etc.

3. Required contextual understanding

a. Knowledge of human development and personality development.

b. Development of abnormal behavior and dysfunction.

c. Knowledge of the Diagnostic and Statistical Manual (DSM) categories to match assessment with group membership criteria.

d. Knowledge of crisis theory and the role it plays in individual and in group work.

4. Related required components

a. Special screening attention because members can come from a wide range of psychological and emotional disturbance populations. Individuals with character disorders or poor reality contact are not good prospects for group psychotherapy.

b. Leader competence to recognize and to deal with crucial behaviors: self-defeating, antagonistic, extremely dysfunctional, dangerous, disruptive, etc. May require the leader's direct intervention (even physical) or hospitalization.

c. Gradiated goal achievement, recognition of incremental gains, increased support, and repeated group involvement are probable.

Note: Some theorists make a distinction between guidance groups, counseling groups, and therapy groups. Individual treatment professionals often use the terms counseling and therapy interchangeably, BUT Group work professionals consider them as dealing with three different levels of severity of problems.

X. Other Types of Group Work

A. T-Groups (Training Groups)

1. May be called laboratory-training groups or sensitivity groups; called microlab if short in duration.
2. Focus on human relations processes in business settings; help people from organizational settings develop human relations skills by examining the group process rather than personal growth.
3. Are associated with the National Training Laboratory and Kurt Lewin. The National Training Laboratory was established under the National Education Association to sponsor "T-Groups" (basic skill training groups). Leland Bradford guided T-group development.

B. Self-Help or Support Groups

1. Members all have the same issue to deal with (weight, grief, alcohol).
2. Members learn from and receive support from each other.
3. Membership is voluntary.
4. The leader is not necessarily a professional.
5. Many follow the Alcoholic Anonymous 12 steps and are therefore called 12-step groups.
6. Over half a million self-help groups exist in the U.S. with over 15 million members.

C. Encounter Groups

1. Emphasize personal growth.
2. Are associated with Rogers. The focus is on the here-and-now experience and includes the I-Thou encounter. Marathon groups are the most commonly known type.

D. Marathon Groups

Rely on long sessions (over a weekend or several days) to break down defenses and facades of members so the members can confront issues in an honest, real, and genuine way.

XI. What Research Says about Group Work

- A. While group work is both popular and effective, group work in general has not been proven to be superior to other modes of treatment. Research says group work works, just not necessarily better.
- B. Outcome based research has concluded that groups are effective.
Outcome based research asks: “Where the goals met?”
- C. Process based research has not been able to determine why or how groups are effective.
Process based research attempts to determine what transpired within the group to allow it and/or its members to reach its desired goals.
- D. In particular, studies in group work are not often well controlled, e.g. the independent variable has not been scientifically defined.
- E. Research studies have not been able to pinpoint the “most important” characteristics that propel a group leader to the position of “great group leader.” Flexibility, enthusiasm, and common sense have been shown to be slightly helpful.
- F. Group work is predicted to become focused on forming groups that will deal with a broader spectrum of issues than is now seen with most groups. Whereas currently most groups have a specific, narrow focus (anger management, for instance), a “comprehensive life-skills model” would afford the opportunity to present preventive mental health skills. As this transition is made, the leader of a life-skills group would function as more of a trainer than a counselor. The need for “therapeutic groups” should lessen.

XII. Miscellaneous Information

- A. **Dynamic** and **dynamics** imply change and movement.
- B. **Laboratory training** is a generic term that means learning through experience.
- C. **Sensitivity** groups are groups whose direct focus is on personal and interpersonal issues.
- D. **Consciousness-raising** has a societal or political emphasis, such as raising the consciousness of women about their own power, of men about women's needs, of whites about minorities, etc.
- E. **Therapy** attends to people's unconscious needs and their past in an effort to bring about personality change.
- F. **Counseling** focuses on conscious problems that may be social, educational, vocational, or personal. Counseling does **not** focus on neurotic or psychotic disorders. Counseling attempts to bring about resolution within a relatively short period of time.
- G. **Open-ended** groups have no stated ending date or number of sessions.
- H. **Sociograms** are pictorial representations of a group's interactions. Moreno and Jennings were the first to graphically display the affiliations and interactions of group members.
- I. **Group Content** refers to the topic of discussion within the group.

GROUP THERAPY THEORIES AND TECHNIQUES

Group therapy models have, with a few exceptions, grown out of the individual counseling theory models discussed in the chapter on Counseling Theories, Methods, and Techniques of this manual. Building on the foundation laid in that chapter, only a brief overview of the major group therapy models are presented here. The basic philosophies hold true; the techniques and the roles of the leaders and members are just adapted to the group setting.

I. Psychoanalytic Groups

A. Theoretical Basis

1. The psychiatrist and psychoanalyst Alexander Wolf first applied psychoanalytic principles and techniques in groups in 1938 as he tried to help people that could not afford intensive individual therapy. His success led him to adopt group therapy as his primary therapy mode (Corey, 2000).
2. As with individual psychoanalytic therapy, group members work through repressed conflicts to restructure their personality and character. The individual's unconscious is explored, particularly the first six years of life.
3. A typical psychoanalytic group will go through these six stages in development:
 - a. Preliminary individual analysis to determine suitability for the group
 - b. Rapport through interpretation of dreams and fantasies
 - c. Free association interaction
 - d. Analysis of resistance
 - e. Analysis of transference
 - f. Conscious personal action and social integration

B. Leader's Role

The leader addresses members' defense mechanisms, directs the focus to early childhood, and helps members work through transference.

C. Members' Roles

Members give feedback based on their observations of members' defense mechanisms. Members attempt to bring the unconscious to the conscious through free association to their dreams, interpretation of dreams, and exposing their own resistances (Gazda, 2001).

D. Techniques

A group "go round" is frequently used to begin a group meeting to aid free association. Interpretation, dream analysis, analysis of resistance, and analysis of transference are all acceptable techniques.

II. Adlerian Groups

A. Theoretical Basis

1. While Freud based his work on the individual psychodynamics of neurotic, affluent patients, Alfred Adler showed a social concern for the common person. He couched his psychological concepts into practical methods for a diverse population. He chose the term “individual” psychology to denote the struggle of individuals to become all that they could be (Corey, 2000).
2. Rudolf Dreikurs refined Adler’s concepts into a streamlined, teachable system that could be applied to education, preventive mental health, family life, and, particularly, group psychotherapy. He incorporated groups into his busy psychiatric practice in 1928 and found them to be an effective means of reaching people (Corey, 2000).
3. As with one-on-one Adlerian therapy, group members move toward a more positive self-esteem as they explore their early family environment (birth order and early experiences) to gain insight into mistaken goals and self-defeating behaviors.
4. A typical Adlerian group will progress through **four phases**:
 - a. Establish and maintain relationship
 - b. Assessment
 - c. Insight
 - d. Reorientation

B. Leader’s Role

The leader supports the goals of the members by examining their goals to gain further understanding. The leader can then encourage members, help assess and clarify problems, and allow members the freedom to remember and to interpret early childhood experiences.

C. Members’ Roles

Members commit to be active members: to state goals openly, to deal openly with trust issues, to examine the affect of family structure on current behavior, to take responsibility for one’s actions, and to search out and admit faulty motivations (Fehr, 1999).

D. Techniques

Adlerian techniques are typically educational in nature and intended to invoke insight. Motivation and lifestyle are evaluated. Confrontation, acting “as if,” contracts, modeling, paraphrasing, encouragement, etc. are all acceptable techniques.

III. Psychodrama Groups (Jacob Moreno)

A. Theoretical Basis

1. Jacob Moreno (1889-1974) discovered that both the actors and the audiences of improvised theatrical representations of current events and topics experienced catharsis (a release of pent-up feelings and emotions) as the actors and audience members related their reactions to the performances and discussed how they might have played roles differently (Corey, 2000). These experiences led Moreno to develop specialized group methods and therapeutic techniques that evolved into what became known as psychodrama.
2. Creativity, defined by Moreno as the expressing of God's purpose, became one of Moreno's central concepts, along with other themes that he felt were ignored in other theoretical approaches: fostering creativity with **spontaneity** and the openness, newness, and willingness to take risks that accompanies it, **encountering** significant others in dramatization, **dealing** with past events as though they were occurring **in the present**, the two-way flow of feelings between people which Moreno called **tele**, **reality testing**, and **role theory** (not role playing which is solution oriented but role dramatization which is insight oriented).

B. Leader's Role

The psychodrama leader is a director who fosters strong group bonding (necessary for group members to feel comfortable enough to participate), who encourages intense participation, and who facilitates the integration of what has occurred for the "protagonist" by requesting feedback from group members.

C. Members' Roles

Members willingly and intensively participate physically, emotionally, and cognitively. A group member acts as a **protagonist** and chooses a conflict to dramatize in the group. Group members participate as significant others or objects for the protagonist. They then share and interpret on a personal level, not cognitive or analytical. An essential element of the education of the group members is the discussion and the processing of the dramas (Fehr, 1999).

D. Techniques

Sessions usually begin with warm-up exercises which may include musical expression, light dramatic scenes, dancing, guided fantasy, drawing, a "go-around," etc. The second stage is the action stage which focuses on acting out and working through past, present, or future situations. Presentation of self and others, interviewing self and others, soliloquy, time travel, and role reversal, etc. are all employed at different times. The last stage begins with the sharing of non-judgmental observations by the protagonist and by other group members. Discussion techniques, a solution roundtable, personal interpretation, etc. may then be used to provide closure.

Perhaps the greatest contribution of psychodrama is its ability to be integrated into most other group therapy modalities.

IV. Existential Groups

(Irvin Yalom; also May, Frankl, Jourard, Maslow, Bugental, Moustakas)

A. Theoretical Basis

The existential approach is a dynamic approach that recognizes four ultimate concerns in the human existence: death, freedom, isolation, and meaninglessness (Yalom, 1980). Existentialism assumes we are free and responsible for the choices and the actions that make up our lives. Therefore, existential groups encourage members to explore choices that would represent an honest exploration of themselves, that would widen their perspectives on themselves and the world around them, and that would make life meaningful.

B. Leader's Role

The existential group leader facilitates a therapeutic alliance amongst group members as well as between him or herself and the group. The leader's input is purposefully subjective so as to encourage group members to express their subjective feelings (Fehr, 1999).

C. Members' Roles

Members challenge their value systems in the "safe" group setting and determine if they are making honest evaluations. Members reflect on accomplishments and gauge their satisfaction and authenticity levels. Members, with the help of the group leader, deal with the anxiety that surfaces as one accepts freedom, responsibility, and the inevitability of death.

D. Techniques

Experiencing the present moment of and with the client is key, so leaders choose techniques from whatever orientation they feel will facilitate this subjective understanding. The leader sets the tone of the group by "being" and "becoming," not "doing" (Corey, 2000).

V. Person-Centered Groups (Carl Rogers)

A. Theoretical Basis

The focus in person-centered groups is on meanings, feelings, insight, affect, and personal attitude. Three environmental attitudes provide the backdrop for a person to achieve self-actualization: **genuineness, unconditional positive regard, and empathy**. Change toward wholeness and self-actualization occurs as both the leader and group members create these **core conditions** (Fehr, 1999).

A typical person-centered group will go through these stages:

1. milling around
2. resistance
3. description of past feelings
4. expressions of negative feelings
5. exploration of meaningful material
6. expression of here-and-now interpersonal feelings
7. development of a healing capacity
8. self-acceptance
9. cracking of facades
10. feedback
11. confrontation
12. helping relationships outside group
13. basic encounter
14. closeness
15. behavior

B. Leader's Role

The group leader functions more like a guide than a director and is process oriented as he or she models the three core conditions while allowing the group to move in the direction it chooses.

C. Members' Roles

Members formulate their own goals, encourage and support other members, express feelings, and move to greater genuineness. Becoming more internally focused results from further self-exploration.

D. Techniques

Since there is no formal, set structure, few planned activities are presented to the group. The leader and the members exhibit the following: active listening, showing respect, reflecting, clarifying, self-disclosing, encouraging, and embodying the three core conditions.

VI. Gestalt Groups (Fritz Perls)

A. Theoretical Basis

The Gestalt paradigm holds that as an individual becomes aware of his or her own thoughts, feelings, senses, and fantasies that personality change will occur, problems will be solved, and impasses will be identified and resolved. The focus is on the “here and now” and characterized by action and insight (Fehr, 1999).

B. Leader’s Role

The leader uses “how” and “what” questions while pointing out unauthentic behaviors and maintaining a member and process oriented environment. Both verbal and nonverbal messages are noted as well as any resistances.

C. Members’ Roles

Members choose the “feeling issues” to be explored and acted out in the group. “I” statements and acting out unfinished business from early life are key concepts. Offering and receiving feedback and taking responsibility for becoming aware of and dealing with their own unfinished business are fundamental tasks of members (Corey, 2000).

D. Techniques

Action-oriented techniques are particularly favored by the Gestalt group leader including but not limited to role playing, how and what questioning, the empty chair, dialogues with self and others, exaggerating behaviors, dream work, and fantasies.

VII. Transactional Analysis Groups

A. Theoretical Basis

Transactional Analysis is an interactional modality and structural analysis founded on Eric Berne's belief that individuals make decisions based upon current beliefs. Identifying illogical beliefs is the catalyst for change as a revised basis for decision-making must be formulated. Thus, individuals' control what they think, do, and feel (Fehr, 1999).

B. Leader's Role

The TA group leader educates members about the three ego states (parent, adult, and child) and about the language and process of TA. The group is leader centered and is both process and outcome oriented.

C. Members' Roles

Members identify goals and commit to contracts for change. They explore the games they play, decide how they will change, and then plan specifically how a change in behavior, thinking, or feeling will occur.

D. Techniques

Contracts are the fundamental technique in TA groups. Other techniques include imagery, fantasy, homework, psychodrama, role-playing, cognitive and affective techniques, and script and game analysis.

VIII. Behavioral Groups

A. Theoretical Basis

Behavior therapy is grounded in learning theory: factors of the human experience, such as emotions, cognitions, and behaviors, are learned and can, therefore, be relearned or unlearned. Overt problem behaviors are dealt with; insight or self-understanding is not sought. Testing, empiricism, and clear goals are key elements of this modality.

B. Leader's Roles

The behavioral therapist is an active and directive teacher. The leader prescreens, interviews, and educates members on the behavioral group process. The leader actively assists with goal setting, teaches self-management skills, supports members' behavioral undertakings, monitors progress, facilitates therapeutic alliances between group members, and encourages the maintenance of targeted behaviors by follow-up interaction with group members after the group has terminated (Fehr, 1999).

C. Members' Roles

Members come into the group pre-committed to a contract for behavior change and are required to agree to the specified behavior changes. Progress is reported weekly; logs are sometimes required. Members practice new behavioral roles, support other group members in their new behaviors, and agree to a follow-up session after the group terminates.

D. Techniques

As members attempt to fulfill their contracts for behavior change, many techniques and strategies are applied including modeling, behavior rehearsal, role-playing, reinforcing, contingency contracting, cognitive restructuring, desensitization, homework, problem solving, assessing, and feedback.

IX. Rational Emotive Behavior Therapy Groups (REBT) (Albert Ellis)

A. Theoretical Basis

The Rational Emotive Behavior Therapy modality views problems as stemming from people's responses, processing, and interpretation of external events. By replacing irrational beliefs with a more rational cognitive processing, members reject self-defeating behaviors (Corey, 2000).

B. Leader's Role

The REBT leader is both process and outcome oriented and is both an active teacher and confronter. The leader shows how cognition leads emotions and behaviors and how to identify and overcome irrational beliefs. The leader challenges, confronts, convinces, probes, and encourages new thinking and behavior patterns.

C. Members' Roles

REBT members must concentrate and work on their cognitive processes. Outside practice is required and members learn to rationally and logically discuss their own and others' irrationalities.

D. Techniques

Educational techniques are mainly employed with the A-B-C-D-E of behavior used consistently. Role playing, behavior rehearsal, desensitization, cognitive restructuring, group discussion, teaching, homework, and confrontation are all acceptable REBT techniques.

X. Reality Therapy Groups (William Glasser)

A. Theoretical Basis

Current behavior should meet current needs; problems arise when individuals make irresponsible choices and use ineffective behaviors. By increasing control over conduct and substituting new behaviors and choices, quality of life is enhanced. William Glasser, the founder of Reality Therapy, believed that we as individuals may be the product of our past experiences, but only victims of the past if we choose to be so. Making excuses and blaming others is not accepted (Corey, 2000).

B. Leader's Role

The RT group is leader centered and outcome oriented. The leader keeps the group rational and action oriented. The leader encourages facing reality and evaluating current behaviors in light of current needs.

C. Members' Roles

RT group members must engage in honest self-evaluation. They must be willing to assess their wants and needs and to evaluate current behaviors based on that evaluation. Members construct a plan for change and commit to it, thereby taking greater control of their lives.

D. Techniques

Since ascertaining needs and contracting for behavior that meets those needs is of paramount concern in the RT group, the leader uses a multitude of techniques to accomplish this end including open group discussions, questions, avoiding punishment, paradox, homework assignments, confrontation, role-playing, asking for commitment, etc.

XI. Developmental Group Counseling (Life-Skills Training) (George Gazda)

- A. In an attempt to provide an approach to group counseling that would be useful at all age levels, George Gazda has organized generally accepted classifications of human development (psychosocial, moral, affective, ego, cognitive, vocational, and physical/sexual) into four generic life-skill areas:
- 1.) interpersonal communication/human relations,
 - 2.) physical fitness/health maintenance,
 - 3.) identity development/purpose in life,
 - 4.) and problem solving/decision making.

These life-skills are then viewed in relationship to four settings:

- 1.) home and family,
- 2.) school,
- 3.) work, and
- 4.) the community at large (Gazda, 2001).

Gazda feels that since most of Western culture is organized on the basis of expected progressive development, that the concept of developmental tasks has wide applicability.

- B. The primary mode of group counseling for preschool and early school-aged children (ages 5-9) is **active play**. Thus, the play group involves modeling, psychodrama, behavior rehearsal, coaching, and group feedback.
- C. **Activity-interview group counseling or activity group counseling** is appropriate for the preadolescent ages 9 to 13. An activity is used to involve the group. This participation lowers inhibitions and defenses and gives way to interpersonal interactions.
- D. Since adolescents and adults are generally verbally efficient, **interview group counseling** is considered to be the preferred mode of treatment for these ages. Meichenbaum's cognitive-behavior integrative approach is recommended by Gazda (2001) as being most consistent with the developmental model:
- Phase 1 is self-observation;
 - Phase 2 is described as initiating cognitions and behaviors that interfere with the maladaptive ones;
 - Phase 3 involves the counselee exhibiting coping behaviors and accurately expressing the changes verbally.
- E. The group therapist is responsible at each age level to deal appropriately with developmental tasks and expectations. Group member selection and group composition, group size, media, and the setting should all be developmentally appropriate.
- F. By the late 1970s, Gazda had finalized a life-skills training model that runs parallel in most respects to his developmental counseling model. He developed 10 basic assumptions regarding the acquisition of life-skills which basically say that life-skills are acquired in sequential order and cannot be mastered before a previous component is mastered. Also, Gazda suggested that there is an optimal age or time for a life-skill to be acquired. As such, life-skills training is either of a preventive or a remediation nature and should not be confused with therapy.

Chapter 9

Professional Orientation & Ethics

PROFESSIONAL ORIENTATION AND ETHICS

NCE — Chapter 9

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Professional Orientation and Ethics

NCE — Chapter 9

HISTORICAL PERSPECTIVE

I. 1900's

- The roots of the counseling profession can be traced to Frank Parsons, who opened the Boston Vocational Bureau in 1908. The bureau was the first of its kind and was more than simply a center for listing job openings.
- Parsons believed that people should be encouraged to choose their own vocations rather than simply following in their fathers' vocational footsteps.
- According to Parsons, the vocational counselor should carefully listen to the desires and feelings regarding what people want to do vocationally in life.
- This process was the forerunner of the essential feature of counseling.
- Parsons developed a unique methodology that included the use of a self-inventory that measured interests, aptitudes, limitations, moral character, appearance, motivations, and dispositions (Nugent, 2000). Client-counselor interaction was emphasized as the results of the survey were examined to determine the appropriate vocation for the client.
- The terms **counseling** and **guidance** were used synonymously by Parsons and others for this process of emphasizing both counselor-client interaction and the giving of advice. However, **guidance** was the most popular term during these early years.

II. 1910's and 1920's

- The superintendent of schools in Boston was impressed by Parson's work and designated over one hundred teachers to receive training as vocational counselors.
- In 1909, Frank Parsons' revolutionary work *Choosing a Vocation* was published. In 1910, the first vocational guidance conference was held.
- The National Vocational Guidance Association (NVGA) was established in 1913 as the first professional organization of the counseling field.
- Parson's pioneering efforts and publications succeeded in creating guidance counseling as a new helping profession and earned him a place in history as the "father of the guidance movement in American education" (Gibson & Mitchell, 2003).
- Parson's emphasis on self-exploration as a part of vocational guidance lost emphasis soon after World War I. During World War I, the U.S. Army asked psychologists to develop assessment devices to screen out unfit draftees, to place draftees in appropriate jobs, and to select qualified persons for officer training (Gibson & Mitchell, 2003).
- Following the development of the Army Alpha and Beta Group Intelligence Tests, testing and assessment was greatly emphasized.
- This emphasis had a profound effect on the direction of vocational counseling and guidance.
- During the 1920's, the field of educational guidance expanded in the schools while vocational guidance expanded in social agencies (Nugent, 2000).

III. 1930's and 1940's

- During the 1930's and '40's, two movements emerged that would affect the direction of counseling and guidance.
- The first was the **clinical counseling** movement, which emphasized testing and diagnosis.
- The other movement was the practice of “**non-directive**” **counseling**, which emphasized the nature of the counselor-client relationship. Carl Rogers, whose *Counseling and Psychotherapy* text was published in 1942, was one of the early proponents of this form of counseling.
- These two movements presented the new profession with a choice about its identity. Along with these movements, the publication of *Workbook in Vocations* by Proctor, Benefield, and Wrenn in 1931, which was the first to give formal recognition of the process of counseling as a psychological process, moved the profession to emphasize counseling as the most significant activity of counselors (Gibson & Mitchell, 2003).
- After World War II ended, the growth and development of counseling was thrust forward as substantial numbers of veterans and civilians needed psychological help – more psychological help than was available through the current psychiatric channels.
- Counseling centers on major college campuses were created as the VA provided funding for free vocational counseling for all veterans (Nugent, 2000).

IV. 1950's

- In the 1950's, the pioneering work of Donald Super replaced vocational guidance with **counseling** psychology. Super, in his article “Transition from Vocational Guidance to Counseling Psychology” (1955), wrote that “growth of interest in psychotherapeutic procedures.....became even greater than interest in psychometrics”(Super, 1955, p. 4; Nugent, 2000).
- The Division 17 of the American Psychological Association (APA) also made a shift in emphasis when it changed its name from the Division of Counseling and Guidance to the Division of Counseling Psychology. However, APA Division 17 was only for psychologists with doctorates and so excluded the majority of counselors.
- In response, the 1950's saw the development of a number of counseling-related professional associations.
- In addition, the National Defense Education Act (NDEA) of 1958, which provided funding to encourage scientific and academic development in schools, provided for a significant increase in the number of school counselor training programs (Nugent, 2000).

V. 1960's and 1970's

- Counseling spread so rapidly in the schools and colleges in the 1960's and 1970's that supply could not keep up with demand. However, counselors lacked a clear understanding of their role and function and often lacked adequate training.
- In response, leaders in both the American Personnel and Guidance Association (APGA) (formed in the early '50's) and APA Division 17 proposed the development of training standards (Nugent, 2000).
- By the late 1970's, an obvious need existed for a terminal master's degree in community mental health counseling (partly in response to the Community Mental Health Act of 1963) along with certification and state licensure.

VI. 1980's and 1990's

- The profession of counseling came to age in the 1980's.
First, counseling received a boost from the contributions of various therapeutic approaches. These approaches included cognitive theories, family systems theory, multicultural counseling, and approaches based on theories of human development (Nugent, 2000).
Second, the number of states passing licensing laws increased through the 1980's and into the 1990's.
- The counseling profession expanded its services in the 1990's to meet the needs of a multicultural society. The services included career counseling, life skills development, substance abuse counseling, and counseling for sexual assault and violence.
- In 1996, the Mental Health Insurance Parity Act was passed which prevented health plans from unequally capping dollar amounts for mental health services.
- Additionally, counselors practicing in the 1990's were increasingly confronted with the restrictions imposed upon them from managed care (Gibson & Mitchell, 2003; Nugent, 2000).

FORMATION OF THE COUNSELING PROFESSION

I. Professional Organizations

- The two professional organizations specifically designed for counselors are the :
American Counseling Association (ACA) and the
American Psychological Association (APA) Division 17.
- These two associations uphold standards specifically designed for training counselors to counsel persons with normal developmental problems.
- APA Division 17 is the major organization for counseling psychologists
- ACA is the major organization for professional counselors.
- In July 2002, the ACA celebrated its 50th anniversary. Originally, ACA began as the American Personnel and Guidance Association (APGA) and then became the American Association for Counseling and Development (AACD). The organization changed its name to the American Counseling Association in 1992. Throughout its history, the ACA was the unifying force that established and maintained counseling as a profession (Nugent, 2000). ACA currently publishes the *Journal of Counseling and Development* and *Counseling Today*.

A. The American Counseling Association's Divisions

The ACA is organized into 18 divisions. These divisions are the:

1. Association for Assessment in Counseling (AAC)
2. Association for Adult Development and Aging (AADA)
3. American College Counseling Association (ACCA)
4. Association for Counselors and Educators in Government (ACEG)
5. Association for Counselor Education and Supervision (ACES)
6. Association for Gay, Lesbian and Bisexual Issues in Counseling (AGLBIC)
7. Counseling Association for Humanistic Education and Development (C-AHEAD)
8. Association for Multicultural Counseling and Development (AMCD)
9. American Mental Health Counselors Association (AMHCA)
10. American Rehabilitation Counseling Association (ARCA)
11. American School Counselor Association (ASCA)
12. Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC)
13. Association for Specialists in Group Work (ASGW)
14. International Association for Addictions and Offender Counselors (IAAOC)
15. National Career Development Association (NCDA)
16. National Employment Counseling Association (NECA)
17. Counselors for Social Justice (CSJ)
18. International Association of Marriage and Family Counselors (IAMFC)

Each of these divisions produces their own publication, usually in the form of a journal.

B. Counsel for Accreditation of Counseling and Related Education Programs (CACREP)

- In 1981, the APGA (now ACA) established the **Council for Accreditation of Counseling and Related Education Programs (CACREP)** to establish criteria to develop standards and to accredit **master's and doctoral level** counselor training programs.
- Webster defines accreditation as “the recognition of an educational institution as maintaining standards that qualify the graduates for admission to higher or more specialized institutions or for professional practice.”
- Only programs can be accredited, not individuals or academic departments.
- CACREP has established eight core curricular areas required for accreditation:
 1. Professional Identity,
 2. Social and Cultural Diversity,
 3. Human Growth and Development,
 4. Career Development,
 5. Helping Relationships,
 6. Group Work,
 7. Assessment,
 8. Research and Program Evaluation(Gibson & Mitchell, 2003; Nugent, 2000).

C. The National Board of Certified Counselors

- The National Board of Certified Counselors, Inc. (NBCC) was established in 1982 by the APGA (American Personnel and Guidance Association) to establish and monitor a national certification system.
- This system was designed to identify counselors who have met NBCC standards in their training, experience, and performance on the National Counselor Examination for Licensure and Certification (NCE).
- The NBCC is now an independent credentialing body with close ties to ACA (Gibson & Mitchell, 2003).

II. Credentialing of the Profession

A. Certification

- Counselor certification is a process that recognizes the qualification of individuals to engage in the professional practice of counseling.
- Normally, certifications are given by professional organizations, though states or training facilities may also offer certifications.
- Currently, the NBCC offers certification in six specialized areas:
 1. Career counselor,
 2. Gerontological counselor,
 3. School counselor,
 4. Mental health counselor,
 5. Community counselor, and
 6. Addictions counselor (Nugent, 2000).
- States also offered specialty certifications for specific settings, and before the establishment of state licensure, certification was the only credential in counseling offered by some states. For example, school counselors are required to be certified through the state department of education in all 50 states (Nugent, 2000). School certification limits the counselor to counseling only in schools within the state (Cottone & Tarvydas, 2003).

B. Licensure

- Licensure pertains to the legal status of the practice of counseling and protects both the public and the profession.
- Licensure is dependent upon the state laws that control and regulate the counseling profession. State laws include descriptions of the nature and limits of counseling practice and descriptions of exempt settings (Cottone & Tarvydas, 2003).
- Currently, 46 states have licensing laws for counselors. The state licensure statute to establish the independent practice of counseling may restrict the use of the title “counselor” (“Title Act”) and/or the practice of counseling (“Practice Act”).
- Historically, certification or registration by states limited the use of a professional title but not necessarily the practice (Vesper & Brock, 1991).
- Licensure is distinguished from certification in that licensure:
 - a. Enables the counselor to practice independently (i.e., in private practice for a fee),
 - b. Is regulated by state licensing boards, and
 - c. Is required for third party payment
(Cottone & Tarvydas, 2003; Gibson & Mitchell, 2003; Nugent, 2000).
- Licensure usually has extensive educational and training requirements.
- A master’s degree in the field is normally required, though some specialty licenses in some states may not require a graduate degree (e.g. Licensed Chemical Dependency Counselor (LCDC) in Texas).
- Some states provide recognition as a **registered counselor**.
- The differences between licensure and certification are complicated and vary by state. For example, Washington has no educational, experience, or testing requirements to be a registered counselor. However, registering with the state does make the registered individual subject to review and disciplinary action by the state including loss of registered status, which would mean the person could no longer practice. In California, on the other hand, a “registered” professional counselor (RPC) is required to have a master’s degree, obtain post-graduate clinical and supervision hours, and pass a written examination. These requirements are equivalent to the licensing requirements for professional counselors in states with counselor licensure. California does not currently have a “license” as a professional counselor (see <http://california-registry.org> and <http://www.counselingseattle.com/consumer/2.htm#difference>).

C. Codes of Ethics and Standards of Practice

- Fundamentally, ethical codes are developed by professional associations and licensing boards to protect and promote the welfare of clients (Remley & Herlihy, 2001). Other purposes for codes of ethics include:
 1. Educate members of the profession about ethical conduct,
 2. Enhance the public's trust in the profession,
 3. Provide a means to ensure accountability by enforcing standards,
 4. Serve as a catalyst for improving practice,
 5. Protect the profession from government intrusion by allowing the profession to regulate itself,
 6. Help control internal disagreement providing stability within the profession, and
 7. Protect practitioners by providing standards by which their practice could be judged in the case of a suit or complaint(Remley & Herlihy, 2001; Gibson & Mitchell, 2003; Herlihy & Corey, 1996; Mappes, Robb & Engels, 1985; VanHoose & Kottler, 1985).
- Codes of ethics represent the values of a profession and the standards of conduct for the membership (Gibson & Mitchell, 2003).
- The ethical practice of counseling can occur on two levels:
mandatory ethics and **aspirational ethics**.

Mandatory ethics focuses on compliance with minimal standards of laws and ethical codes. Counselors who focus only on mandatory ethics may be vulnerable to denial, distortion, discounting, or dismissing of ethical questions and issues (Pope & Vasquez, 1991).

The second level is a more ethically sophisticated level referred to as **aspirational ethics**. When counselors practice aspirational ethics, they practice the highest standards of conduct and demonstrate an understanding of the spirit behind the code and the principles underlying the code rather than simply meeting the letter of the code (Corey, Corey, & Callanan, 2003; Remley & Herlihy, 2001; Cottone & Tarvydas, 2003).

- The current ACA code of ethics is in its fifth version since it was first adopted in 1961. In 1995, the ethical standards of the association were presented in two separate documents— **The Standards of Practice** and **The Codes of Ethics**.

The Standards of Practice are relatively brief and focus on minimal behaviors required by professional counselors (**mandatory ethics**).

The Code of Ethics is a lengthier, more detailed description of standards of practice and includes **statements** reflecting the ideals of the profession (**aspirational ethics**) (Herlihy & Corey, 1996).

D. Summary Outline of the ACA Code of Ethics and Standards of Practice (ACA, 1995)

Section A: The Counseling Relationship

- The primary responsibility of counselors is to respect the dignity of and to promote the welfare of clients.
- This section of the Code addresses issues of discrimination, disclosure, dual relationships, sexual intimacies with clients, fees and bartering, abandonment, termination, and use of computer technology.

Section B: Confidentiality

- Counselors respect their clients' right to privacy and avoid illegal or unwarranted disclosure of confidential information.
- This section addresses issues of limitations of confidentiality, group and family situations, record keeping, reporting of research, disclosure or transfer of records, supervision, and consultation.

Section C: Professional Responsibility

- Counselors are to exhibit competence in their practice, including reading, understanding, and following the Code of Ethics and Standards of Practice.
- Boundaries of professional competence, obtaining proper training and supervision, monitoring effectiveness, continuing education, refraining from practice when impaired, accurate advertising, honest representation of credentials, avoidance of sexual harassment, accurate reporting to third parties, and respect for other professionals are some of the issues included in this section.

Section D: Relationships with other Professionals

- Counselors clearly define their roles and establish working agreements with other professionals.
- This section addresses issues of work conditions, evaluations, development of self and staff, selection of staff, professional conduct, consultation, and subcontractor arrangements.
- This section also addresses the acceptance of fees for referrals from other professionals, as well as the acceptance of a fee from a client privately/directly when the client is entitled to services through the agency for which the counselor works.

Section E: Evaluation, Assessment, and Interpretation

- Counselors should be competent in administering and interpreting assessment instruments for which they have been properly trained and in utilizing the information in a competent and ethical manner.
- The appropriate use of assessment instruments, limits of competence, obtaining informed consent, choosing instruments, and proper reporting of results are addressed in this section.

Section F: Teaching, Training, and Supervision

- Counselors who teach or supervise should be skilled as teachers and practitioners, and develop and maintain appropriate relationships with students and supervisees.
- This section addresses such issues as boundaries with students and supervisees, sexual relationships with students or supervisees, teaching and supervision competence, education and training program development, evaluation procedures, and dual relationships.

Section G: Research and Publication

- Counselors design, conduct, and report research in a manner consistent with ethical principles, laws, regulations, and scientific standards.
- This section addresses informed consent, precautions to avoid injury, confidentiality, accuracy in reporting, and other issues related to research with human subjects.

Section H: Resolving Ethical Issues

- Counselors should be knowledgeable of the Code of Ethics and the Standards of Practice and take appropriate action when ethical violations occur.
- Reporting of ethical violations by colleagues, consulting with other counselors when dealing with difficult ethical situations, unwarranted complaints, resolving ethical conflicts, and cooperating with ethics committees are issues addressed in this section.

PROFESSIONAL ACTIVITIES OF THE COUNSELOR

I. Counseling and the Mental Health Professions

- Counselors must work alongside many other mental health professionals. Each of these mental health professions has its history and traditions and it is important for the counselor to be aware of the standards and scope of practice for each.
- **Scope of practice** refers to “a recognized area of proficiency or competence gained through appropriate education and experience” (Cottone & Tarvydas, 2003, p. 49). State licensing statutes typically specify the scope of practice for the profession.
- An individual’s scope of practice is usually narrower than the professional scope of practice and is based on the individual’s specific skills, training, and experience (Cottone & Tarvydas, 2003).

A. Professional Counselors

- Professional Counselors engage in a wide **variety of activities** that include individual assessment, individual counseling, group counseling, marriage and family counseling, school counseling, addiction counseling, rehabilitation counseling, career assistance, research, prevention, education, consultation, and crisis intervention (Cottone & Tarvydas, 2003; Gibson & Mitchell, 2003; Nugent, 2000).
- Professional counselors also work in a **variety of settings** that include elementary and secondary schools, colleges and universities, community mental health clinics, private clinics, inpatient residential facilities, employment offices, vocational rehabilitation centers, correctional facilities, employee assistance programs, and religious organizations (Nugent, 2000).
- Though often used interchangeably, **counseling generally is distinguished from** psychotherapy in terms of the severity of the client’s problems.
- Counseling focuses on situational problems and problems with transitional periods and emphasizes short-term counseling processes (Nugent, 2000).
- Psychotherapy focuses on more serious psychological, emotional, and relational problems and often requires a longer process.
- Counseling is also distinguished from guidance in that guidance specializes in helping clients make educational and career choices (Gibson & Mitchell, 2003).

B. Counseling Psychology ~ Psychologists

- Counseling and counseling psychology developed side-by-side and were once considered sister occupations (Cottone & Tarvydas, 2003). However, training, orientation, and licensing requirements for each are quite different.
- Psychologists, regardless of their specialty, must have a doctorate in psychology (Ph.D., Ed.D., or Psy.D).
- **Counseling and Clinical Psychologists** usually have Ph.D.s.
- In addition to the doctorate, licensure as a psychologist requires one or two years postdoctoral experience supervised by a licensed psychologist. Candidates for a psychologist license must pass stringent examination, which usually requires both written and oral components.
- Unlike psychiatrists, psychologists cannot prescribe medication, though active petitioning of state legislatures for the right to prescribe medication is occurring (Cottone & Tarvydas, 2003).
- Psychologists are qualified to provide psychotherapy or counseling and are trained in the administration and interpretation of a wide range of psychological assessment instruments and techniques.

C. Psychiatrists

- Psychiatrists compose the oldest mental health profession. Psychiatry is a medical specialty.
- All psychiatrists are physicians with a medical degree in either Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) (Cottone & Tarvydas, 2003).
- As physicians, psychiatrists are allowed by law to prescribe medication and to use other physical means to treat mental illness. Since they are the only mental health specialists that can prescribe psychotropic drugs, they often serve a consultative role with other mental health professionals (Gibson & Mitchell, 2003).
- Some psychiatrists receive special training as psychoanalysts, which requires them to undergo long-term analysis and to receive training typically in neo-Freudian or Jungian approaches (Nugent, 2000).

D. Marriage and Family Therapists

- Marriage and Family Therapists focus on relationships between couples and within families.
- Unlike other mental health professions that focus primarily on the individual, marriage and family therapists treat relationships using systems theory (Cottone & Tarvydas, 2003).
- Because marriage and family counseling is within the scope of practice of other mental health professions, some controversy exists over whether marriage and family therapy is a separate profession or simply a set of specialized techniques (Cottone & Tarvydas, 2003).
- About as many states have licensure in marriage and family therapy as those that license professional counselors.
- A master's degree, specialized training, postgraduate supervision, and the passing of an examination are required (Cottone & Tarvydas, 2003).

E. Psychiatric Nurses

- Psychiatric Nurses have received advance training in counseling and therapeutic skills for working with individuals with health problems (Nugent, 2000).
- Training requirements include education leading to the R.N. (registered nurse) certification and certification as either a "psychiatric and mental health nurse" or "clinical specialist" (Cottone & Tarvydas, 2003).

F. Social Workers

- Social Workers are generally trained at the master's level and are specialized in either public policy or clinical social work.
- The **clinical or psychiatric social worker** is trained and licensed to practice as an independent mental health professional (Cottone & Tarvydas, 2003). Clinical social workers emphasize socio-cultural factors contributing to client and family problems and are trained in family therapy.
- Social workers often serve as caseworkers coordinating various therapeutic and social services for clients (Nugent, 2000).
- In terms of level of education, social work is the profession that competes most closely with master's level professional counseling (Cottone & Tarvydas, 2003)

II. Private Practice

A. Advantages and Disadvantages of Private Practice

Vesper & Brock (1991) list a number of advantages and disadvantages of private practice.

Advantages include:

1. autonomy,
2. client follow-through, and
3. caseload control.

Counselors working in public agencies rarely have these advantages.

Disadvantages to private practice include:

1. fluctuating income,
2. isolation, and
3. multiple responsibilities involved in providing client care as well as running a business.

B. Important Issues to Consider Before Opening a Private Practice

Counselors-in-training often idealize private practice without understanding all of the issues of starting and maintaining a small business. Unfortunately, graduate programs offer little training in business administration for counselors. The following issues are important when considering private practice.

In most cases, depending on state law and the services provided by the counselor, counselors must be licensed by the state before opening a private practice (Remley & Herlihy, 2001). Most states allow counselors to engage in various counselor-related activities without being licensed. These activities may include conducting educational workshops and producing written products (Remley & Herlihy, 2001). Haynsworth (1986) lists additional requirements for setting up a private practice:

1. a federal tax identification must be obtained if there are any employees,
2. a business license,
3. worker's compensation insurance or unemployment compensation insurance,
4. employee bonds may be required,
5. liability, property damage, or other types of insurance,
6. compliance with a fictitious or assumed name statute if needed, and
7. additional public filing requirements that may exist.

A business license must be purchased from the appropriate office at a city hall or county courthouse (Remley & Herlihy, 2001). The steps to purchasing and maintaining a business license for private practice are:

1. provide a business address,
2. obtain zoning approval,
3. obtain license,
4. renew business license annually,
5. report gross income at time of renewal, and
6. pay a tax to the city or county (Remley & Herlihy, 2001).

C. Four Typical Business Structures

1. Sole proprietorship,
2. Partnership,
3. Corporation, and
4. Nonprofit Corporation.

1. Sole Proprietorship

Most private practices are sole proprietorships (Remley & Herlihy, 2001). In a sole proprietorship, the individual owns the practice and has sole financial interest in it. This form of practice is considered the simplest and usually the best option for counselors in private practice (Remley & Herlihy, 2001).

2. Partnership

A partnership is the second most popular form of private practice and should be entered into with great caution (Remley & Herlihy, 2001). Though the counselor may like the idea of a partnership because he or she is anxious about going it alone or because of the social benefits of affiliating with other professionals, a number of issues need consideration. Remley and Herlihy (2001) list five arguments against forming partnership:

- a. total agreement on business decisions will be needed,
- b. each partner is liable for the acts of the other partners,
- c. a presumption of equality exists regarding liabilities and profits,
- d. personal assets would not be protected from business debts, and
- e. the dissolution of partnerships can be contentious and expensive.

Group practice, which can be nothing more than private practice counselors sharing office expenses, can provide the opportunity for social interaction and even case consultation with other professionals without the difficulties of a partnership (Nugent, 2000).

3. Corporations

Corporations are complicated and are often affected by various types of legislation and tax laws. The main advantage of incorporation of a private practice is to protect personal assets in the event that the business fails or litigation is rendered against it (Remley and Herlihy, 2001). However, adequate professional liability insurance can protect personal and business assets from loss making incorporation less attractive.

Some advantages to forming a corporation are:

- a. accumulation of assets,
- b. transferability of ownership,
- c. flexible fiscal year,
- d. employee benefits,
- e. some reduction in liability, and
- f. management structure (Weil, 1983).

4. Non-profit Corporations

Non-profit corporations are attractive because of favorable tax laws and the eligibility of certain grants (Remley & Herlihy, 2001; Hamilton, 1990). Counselors pay themselves a salary from the corporation, but do not own or control the corporation (Remley & Herlihy, 2001). A board of directors must be established to qualify as a nonprofit corporation and this can be the main downside to a nonprofit corporation structure for private practice. The board has the power to assert their own interests and to even remove or replace the counselor and take over the business (Remley & Herlihy, 2001).

D. Goals and a Business Plan

Regardless of the form that the counselor establishes for his or her private practice, the practice is a business that must generate enough income to cover expenses (i.e., clerical help, lease of office space, utilities, insurance, etc.) and provide a reasonable living. Goals and an action plan that include the types of cases accepted, services offered, financing, networking, and a timeline to accomplish these things should be clearly established (Vesper & Brock, 1991).

E. The Setting of Fees

In addition, fees must be set that not only reflect what the market will tolerate, but also establish a fiduciary relationship based on fairness (Remley & Herlihy, 2001; Smith & Mallen 1989). Counselors may set whatever fees they choose, however, the ACA Code of Ethics makes clear that in no way should counselors be discriminatory in setting fees (Cottone & Tarvydas, 2003; Remley & Herlihy, 2001).

The private practice counselor will need to establish a number of policies regarding fees. Most counselors use the flat fee (charging everyone the same fee) or some slight variation (Cottone & Tarvydas, 2003). Other options for establishing fees exist. Some counselors, for example, use a "sliding scale" fee structure. A **sliding scale fee structure** establishes the fee based on the amount of income the client generates or the size of their family or some other objective criteria (Remley & Herlihy, 2003). If the private practice counselor chooses this kind of fee policy, he or she must apply it to everyone, including those who receive health insurance reimbursement. To do otherwise would be a fraudulent practice that could lead to serious legal consequences (Remley & Herlihy, 2001). The sliding scale fee structure is controversial with some arguing that it is discriminatory against individuals based on socioeconomic status (Cottone & Tarvydas, 2003).

F. Billing — Collection Procedures

A billing or collection procedure is another policy that must be clearly established by the counselor. Collecting fees from clients can be very uncomfortable for some counselors. Counselors uncomfortable with collecting fees should consider working in an agency rather than private practice (Remley & Herlihy, 2001). The current trend is for counselors to collect fees as services are rendered, except of course when a third party (e.g., health insurance company) is involved (Remley & Herlihy, 2001). This alleviates a number of problems associated with fee collection. Whenever clients are billed, the possibility of the counselor losing that income is increased. If the counselor intends to utilize a collection agency to secure unpaid balances, this policy should be explained to clients when they initially agree to services (Cottone & Tarvydas, 2003; ACA Code of Ethics, 1995). Counselors should never threaten or sue clients for unpaid balances because of the possibility of a countersuit or complaint to a professional board or association based on an allegation of inferior services rendered (Remley & Herlihy, 2001).

G. Missed Appointments and Pro Bono Work

Additional policies that the counselor needs to establish regarding fees include whether or not **missed appointments** will be billed to the client and circumstances in which the counselor will work **pro bono publico**, or for the public good without a fee (Cottone & Tarvydas, 2003; Corey, Corey, & Callanan, 2003). The counselor is expected at times to donate some of his or her services at no fee (or minimal fee). The ACA Code of Ethics states, "Counselors contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (pro bono)" (ACA Code of Ethics, 1995). A counselor may be ethically compelled to give pro bono services to a client when the client can no longer pay or when the insurance company refuses to pay for services and serious issues of the client's welfare are imminent (Cottone & Tarvydas, 2003).

H. Managed Care

Managed care has had significant impact on mental health services and is something that the counselor in private practice will need to understand (Remley & Herlihy, 2001). The idea behind managed care is to lower the cost of health care by limiting covered services. The aim is to limit treatment to only that which will enable the client to function at a reasonable level as soon as possible and to provide preventative services to reduce the overall cost of healthcare (Cottone & Tarvydas, 2003; Remley & Herlihy, 2001).

a. Forms of Managed Care

Managed care can take a number of forms. Various organizations participate in managed care and include:

- a. Health maintenance organizations (HMOs), which use a restricted group of providers to provide specified services at a fixed cost,
- b. Preferred provider organizations (PPOs), which purchase services from specific providers at a reduced rate, and
- c. Independent practice associations (IPAs), which allows consumers to choose independent practitioners and see them in their offices rather than in an HMO facility (Cottone & Tarvydas, 2003).

HMOs, PPOs, and traditional indemnity health insurance are the most common health care plans today (Remley & Herlihy, 2001).

b. Receiving Payment from a Managed Care Entity

For a counselor to receive payment for services from a managed care entity, he or she must be on the company's provider list, which requires the counselor to meet the company's standards (Cottone & Tarvydas, 2003). A managed care contract, established between the company and the provider, specifies the services to be rendered, the amount of money to be paid, the number of sessions allotted to the client, and other limitations (Cottone & Tarvydas, 2003). Managed care companies require a procedure known as utilization review, in which a panel reviews requests for services and decides what services will be allowed and how long treatment will be reimbursed based on diagnosis (Remley & Herlihy, 2001; Ford, 2001). Carefully following the managed care company's policies and demonstrating efficacy are required to remain a provider and receive referrals (Cottone & Tarvydas, 2003; Remley & Herlihy, 2001).

c. Advantages and Disadvantages of Managed Care

Cottone and Tarvydas (2003) list a number of advantages and disadvantages of managed care.

Advantages include:

- 1.) limited cost of services compared to traditional health insurance,
- 2.) increased access to mental health services,
- 3.) no exclusion due to pre-existing condition,
- 4.) increased referral rate, and
- 5.) establishment of quality control and monitoring of standards of practice.

Disadvantages include:

- 1.) limited choice in providers,
- 2.) inability to consult a specialist directly,
- 3.) reduction in the variety of services available,
- 4.) potential overuse of medication, and
- 5.) limited treatment duration.

I. Various Ethical Issues

- Counselors may be confronted with various ethical issues related to client care when working with managed care companies. A temptation exists in a managed care environment to **"upcode"** a client diagnoses, or assign a more serious diagnosis in order to obtain more counseling sessions.
- Likewise, the counselor must resist the temptation to **"downcode"** a client diagnosis to one for which the managed care company will reimburse (Cottone & Tarvydas, 2003).
- Another ethical issue involves **prematurely terminating a client because of a managed care company's refusal to pay for additional sessions believed required by the provider**. In addition to a pro bono policy for this situation, counselors also must consider whether a "duty to appeal" exists that would involve advocating on behalf of the client in appealing a managed care company's decision (Cottone & Tarvydas, 2003).
- Other ethical issues involving managed care include **client abandonment, confidentiality, informed consent, and requirement of diagnoses** (Corey, Corey, & Callanan, 2003; Remley & Herlihy, 2001)

J. Use of Attorneys and Accountants

Counselors in private practice need to utilize attorney and accountant services (Remley & Herlihy, 2001). The following are some situations in which the services of an attorney are required: 1) forming a partnership, 2) signing a lease for office space, 3) the counselor receives a subpoena to release a client's records but the client does not want them released, 4) a health insurance company denies a client's claims because they do not believe you provided the services, 5) you wish to dissolve a partnership (Remley & Herlihy, 2001).

Since a counselor in private practice does not have the expertise or the time to handle all of the financial aspects of the business, an accountant must be retained (Remley & Herlihy, 2001). An accountant or accounting firm can provide the following services: 1) set up a system for recording income and expenses, 2) develop a retirement program for you and for your employees, 3) handle payroll, 4) file income tax returns (Remley & Herlihy, 2001).

K. Advertising

For a private practice to be successful, clients need to find the counselor. Advertising and marketing a private practice is perfectly acceptable and necessary. Hospitals, employee assistance programs, physicians, attorneys, and public service agencies are sources of potential referrals and thus should be included in a marketing plan (Vesper & Brock, 1991).

While advertising and marketing of services is important, the counselor should be careful in how they present themselves to the public. Deception is the major issue of concern when marketing (Cottone & Tarvydas, 2003). The ACA Code of Ethics defines deceptive advertising practices as unethical. The counselor should give honest representation of degrees, credentials, and professional memberships, and avoid making global claims of treatment success (Cottone & Tarvydas, 2003). In addition, the counselor is responsible to correct any misrepresentation or misinformation about his or her credentials that might be made by others (Remley & Herlihy, 2001).

THE ETHICAL AND LEGAL PRACTICE OF COUNSELING

Professional ethics are the agreed upon standards that define what is both “good” as well as the “ideal” practice of the profession and are enforced by professional associations, certification boards, and government regulatory boards (Corey, Corey & Callanan, 2003; Cottone & Tarvydas, 2003, Remley & Herlihy, 2001).

Laws are distinguished from ethics in that laws dictate minimum standards of behavior, rather than ideal standards, and are enforced by the government (Corey, Corey & Callanan, 2003; Remley & Herlihy, 2001).

Sometimes, though relatively rare in counseling, ethics and law can conflict, which requires the counselor to take action in resolving the dilemma (Corey, Corey & Callanan, 2003; Remley & Herlihy, 2001). Very often ethical and legal concerns are intertwined.

I. Ethical Concerns

A. Competence

Competence is both an ethical and a legal concept in that counselors need to meet the minimum standards of performance in order to practice in a given state (legal concept) as well as strive for maximum levels (ethical concept) of knowledge and skills (Remley & Herlihy, 2001). The law demands a minimum level of practice from counselors while ethics promotes the ideal level of practice. The ethical statement of competence in the ACA Code of Ethics is that "Counselors practice only within the boundaries of their competence . . . [and] will demonstrate a commitment to gain knowledge, personal awareness, sensitivity, and skills, pertinent to working with a diverse client population" (Standard C.2.a).

B. Confidentiality

Confidentiality is "the obligation of professionals to respect the privacy of clients and the information they provide" (Handelsman, 1987, p.33; Cottone & Tarvydas, 2003).

Confidentiality more specifically refers to the communication shared in the counseling context. Though the research is mixed regarding how important confidentiality is to clients, it is universally accepted by counseling professionals as essential in building the necessary relationship of trust between the counselor and the client (Remley & Herlihy, 2001).

Confidentiality has been referred to as a "pledge of silence" in which the counselor, through word and deed, actively works to protect client's secrets from disclosure (Remley & Herlihy, 2001; Bok, 1983).

Common limits to confidentiality involve the revelation of child abuse, intent to do harm, and information related to the counseling of a minor to parents or guardians. Information may also be shared when:

1. the counselor is under supervision,
2. when counseling is under court order,
3. when the client consents to disclosure (waiver of confidentiality),
4. when clerical assistants handle client information,
5. in coordinating treatment with other professionals,
6. when the client files a complaint against their counselor, and
7. when criminal action is involved

(Corey, Corey, & Callanan, 2003; Cottone & Tarvydas, 2003; Remley & Herlihy, 2001).

In regards to group counseling, the ACA Code of Ethics does not “guarantee confidentiality” (Standard B.2.a). When doing family counseling, counselors should not disclose information about one family member to another unless consent is given (Standard B.2.b).

C. **Duty to Warn and to Protect**

The duty to warn and to protect presents a challenging issue of confidentiality for counselors. Counselors should exercise reasonable professional skill in:

1. identifying those clients who are likely to do physical harm to third parties,
2. protecting third parties from those clients judged potentially dangerous, and
3. treating those clients who are dangerous (Corey, Corey, & Callanan, 2003; Bednar, et. al., 1991).

The case of **Tarasoff v. Regents of University of California** resulted in a decision that client confidentiality can be compromised when a third party is in danger. The case involved the death of a college girl (Tatiana Tarasoff) by a former boyfriend who, while in counseling, told the psychologist of his intent to kill her. The psychologist informed the campus police who detained the client for questioning. The police allowed him to go after he assured them that he would stay away from her. He later killed her. The court ruled that the psychologist had the “duty to warn” the intended victim. Though Tarasoff has become a benchmark ruling, states have varied in their interpretation of Tarasoff; not all states have clear legal mandate of a duty to warn. Texas, for example, has rejected Tarasoff (Thapar v. Zezulka, 1999). The counselor needs to be aware of the law in the state in which he or she is practicing, understand the ethical issues involved, and obtain consultation when dealing with potentially violent clients (Corey, Corey, & Callanan, 2003).

D. **Continuing Education**

The ACA Code of Ethics states that counselors “should recognize the need for continuing education” (Standard C.2.f) to maintain a reasonable level of competence in the field. A prescribed number of continuing education hours (CEUs) in the form of workshops, seminars, or independent study, is usually a requirement for maintaining state licensure. Questions have been raised about what constitutes an effort to maintain competency since there may be no way to objectively assess whether or not a counselor has maintained competence over time (Remley & Herlihy, 2001).

E. **Dual (Multiple) Relationships**

A dual relationship occurs when a counselor has a professional relationship with a client while simultaneously having a personal, nonprofessional relationship with the same client. Examples of multiple relationships include socializing with clients, providing counseling to friends or family members, becoming involved emotionally or sexually with a client, or combining supervision and counseling with a trainee (Cottone & Tarvydas, 2003). The most recent literature prefers the term “multiple relationships” because it more adequately portrays the counselor-client relationship, which can be complex (Cottone & Tarvydas, 2003). Dual or multiple relationships are not in and of themselves unethical, but become so when clients are exploited. The ACA Code of Ethics warns counselors to avoid those dual relationships that “could impair professional judgment or increase the risk of harm to clients” (Standard A.6.a). Sexual intimacies with current clients are always unethical and are unethical with former clients for a period of two to five years (depending on the ethical code) after termination of professional involvement (Cottone & Tarvydas, 2003). Very little consensus exists regarding the appropriateness of nonsexual dual relationships. Some view dual relationships as always harmful while others view them as a natural part of counseling or at least as unavoidable in some circumstances (Remley & Herlihy, 2003). The ACA Code of Ethics states that, “when a dual relationship cannot be avoided, counselors take appropriate professional precautions . . . to ensure that judgment is not impaired and no exploitation occurs” (Standard A.6.a).

F. Informed Consent

Respecting client autonomy requires that the right of clients to make informed decisions about treatment be upheld by the counselor. Generally, a contractual document that addresses:

1. the therapeutic process,
2. background of counselor,
3. costs of treatment,
4. length of treatment,
5. benefits and risks of treatment, and
6. the nature and purpose of confidentiality

is provided by the counselor at the beginning of treatment (Cottone & Tarvydas, 2003; Corey, Corey, & Callanan, 2003). However, with its many ethical and legal implications, informed consent should be addressed on an ongoing basis (Corey, Corey, & Callanan, 2003). Specifically, the counselor should come back to it from time to time throughout the counseling process.

Informed consent has three levels with ethical and legal implications. To give consent, the client must:

1. possess the ability to make a rational decision (capacity),
2. have sufficient information and be able to understand the information (comprehension), and
3. and be acting freely in the decision-making process (voluntariness) (Cottone & Tarvydas, 2003; Corey, Corey, & Callanan, 2003).

The counselor is responsible to be sure these elements are in place when discussing treatment with the client. Decreased anxiety, compliance with treatment, increased awareness of treatment problems, and more rapid recovery have been associated with proper informed consent procedures in counseling (Pope & Vasquez, 1991; Shaw & Tarvydas, 2001).

G. Recordkeeping

Keeping adequate records on clients has ethical, legal, and clinical implications. Case records are one of the top five areas of legal liability for counselors (Cottone & Tarvydas, 2003; Snider, 1987). The ACA Code of Ethics (1995) states that, "counselors maintain records necessary for rendering professional services to their clients and as required by laws, regulations, or agency or institution procedures" (Standard B.4.a). Specific reasons for keeping adequate records include the following:

1. provide the best possible counseling services,
2. decrease liability exposure and defense against malpractice claims,
3. fulfill requirements for reimbursement,
4. reflect a client's condition at a particular time,
5. document that treatment occurred,
6. useful when transferring a client to another professional (continuity of care),
7. federal and state laws require the practice of record-keeping, and
8. documentation of services for business purposes
(Corey, Corey, & Callanan, 2003; Cottone & Tarvydas, 2003; Remley & Herlihy, 2001).

Information in the client's record belongs to the client. However, the maintenance of the actual records is the responsibility of the counselor. Client records should be stored in a secure manner that protects confidentiality (Corey, Corey, & Callanan, 2003). Access to records should be carefully controlled, the records should be kept for an appropriate period, and procedures for destroying records should be clear (Corey, Corey, & Callanan, 2003).

Counselors should be aware of the length of time required by federal, state, and local laws for maintaining client records. Some suggestions for the length of time to keep records range for 7 to 15 years after termination. Some have suggested that a complete record be maintained for 3 years after last client contact with at least a summary of the records to be kept an additional 12 years (Corey, Corey, & Callanan, 2003). Remley and Herlihy (2001) suggest that records be kept longer than normal in cases where the potential for liability are greater.

An important aspect of record keeping is clarity in the writing of **case notes**. The following points should be remembered when documenting:

1. insure legibility when writing by hand,
2. notes should be grammatically clear and correct,
3. use precise language,
4. avoid jargon,
5. keep notes organized, and
6. document consistently (Mitchell, 1991)

H. Technology

The primary issues involving technology in the counseling field include:

1. electronic storage of client materials,
2. electronic transmission of client information,
3. the use of computer-assisted counseling, and
4. the use of the Internet.

Cottone and Tarvydas (2003) list these reminders for the ethical use of **electronic media**:

1. ethical codes require that the same safeguards be used for both printed and electronic media,
2. privacy protocols are essential to ethical data management,
3. fax transmissions of sensitive material must be carefully controlled,
4. e-mail should not be considered a confidential form of communication, and
5. confidential matters should not be discussed over cellular phones.

Computer-assisted counseling has been around for many years in a number of forms, though it has not gained wide acceptance (Cottone & Tarvydas, 2003). Psychoeducational approaches to counseling, such as career counseling, are most likely to utilize computers. Computerized career counseling has shown to be helpful for highly motivated and goal directed clients (Kivington, Johnston, Hogan, and Mauer (1994)

Online counseling, sometimes referred to as Internet counseling, WebCounseling, telepsychology, cybercounseling, or behavioral telehealth, is gradually being accepted, though not without debate (Corey, Corey, & Callanan, 2003; Cottone & Tarvydas, 2003; Relmey & Herlihy, 2001). The vast majority of states have not enacted statutes addressing online counseling (Cottone & Tarvydas, 2003). The National Board for Certified Counselors (NBCC) approved Internet counseling by adopting the "Standards for the Ethical Practice of Internet Counseling" on November 3, 2001. The Preface includes the following statement:

"These standards govern the practice of Internet counseling and are intended for use by counselors, clients, the public, counselor educators, and organizations that examine and deliver Internet counseling. These standards are intended to address practices that are unique to Internet counseling and Internet counselors and do not duplicate principles found in traditional codes of ethics."
(Cottone & Tarvydas, 2003, p. 196)

II. Legal Concerns

A. Buckley Amendment

The **Family Educational Rights and Privacy Act of 1974 (FERPA, Public Law 93-380)**), also known as the **Buckley Amendment**, gives parents of minors as well as students 18 yrs. old or older two rights: 1) access to educational records kept by the institution, and 2) prevention of the institution from releasing information to a third party (other than another school) without written consent. Parents or guardians of dependent students can be given copies of the students' records without the student's consent. While written consent is not required in the case of transferring a student's record to another educational institution, parents must be notified and must be given copies if they desire them (Remley & Herlihy, 2001).

B. Expert Witness Testimony

Counselors are increasingly appearing in court as expert witnesses. An expert witness is an individual who is qualified by education and experience to provide specialized information to a judge or jury to help them render a decision (Weikel & Hughes, 1993). The judge determines whether an individual qualifies as a competent expert; the counselor does not have to be a recognized authority but simply possess information needed by the court (Weikel & Hughes, 1993). The expert witness is the only witness in court proceedings allowed to express his or her opinion.

A counselor may be called as an expert witness for a variety of cases such as child abuse, sexual abuse, child custody, divorce, addictions, delinquency, negligence or malpractice, and worker's compensation (Weikel & Hughes, 1993; Gibson & Mitchell, 2003). The following are some useful tips for the expert witness: 1) prepare well, 2) be able to justify your conclusions, 3) know the strengths and weaknesses of any assessment instruments used, 4) listen carefully to questions asked and answer concisely, 5) speak clearly, 6) avoid jargon, 7) be professional in physical appearance (i.e., dress) and in the way you present yourself (Weikel & Hughes, 1993).

C. Individuals with Disabilities Education Act (IDEA) (Public Law 94-142; PL 94-142)

Originally called the **Education for All Handicapped Children Act**, it was renamed in 1990 and revised in 1997. The law requires educational institutions to provide the least restrictive environment possible to all students regardless of the nature and degree of their handicap (Cottone & Tarvydas, 2003). School counselors should be aware of the federal guidelines that apply.

D. Libel/Slander

Counselors who make false verbal or written statements about another professional that damage that professional's reputation could be charged with libel or slander (Remley & Herlihy, 2001). False statements that damage a person's character or reputation are referred to as defamation (Huber & Baruth, 1987). Defamation that is written is libel. Defamation that is spoken is slander.

E. Malpractice/Negligence

Professional liability refers to the responsible and legal practice of a profession. If a counselor fails to practice responsibly, he or she may be charged with malpractice.

Malpractice, defined as the failure to render professional services or to exercise the degree of skill ordinarily expected from other professionals, is a legal concept involving negligence that results in injury or loss to the client (Corey, Corey, & Calanan, 2003). **Professional negligence** occurs when the counselor departs from ordinary practice or fails to exercise due care (Corey, Corey, & Callanan, 2003). The most frequent allegations of malpractice involve violations of confidentiality, sexual misconduct, failure to prevent suicide, and other allegations of incompetent treatment (Corey, Corey, & Callanan, 2003).

To succeed in a malpractice claim, these four elements must be present:

1. a professional relationship was established between the counselor and the client (Duty),
2. the counselor was negligent or deviated from the “standard of care” of the profession (Breach of Duty),
3. the client suffered harm or injury that can be demonstrated (Injury), and
4. a causal relationship exists between the negligence of the counselor and the harm claimed by the client (Causation) (Corey Corey, & Calanan, 2003).

Professional liability insurance provides financial protection to the counselor in the event that an allegation by a client of intentional or unintentional harm is made (Vesper & Brock, 1991). The best approach, however, is to avoid allegations by minimizing vulnerability through sound risk management.

F. Privacy

Privacy is a constitutional right to keep certain information concealed. The right to privacy addresses not only the communications between counselor and client but also:

- the disposal of records,
- video/audio recordings,
- not being identified in the waiting room,
- credit card information for billing (where the credit card company will have information of the fact that the person received counseling and from whom),
- the use of computer scoring services,
- as well as many other activities (Cottone & Tarvydas, 2001).

Confidentiality is an ethical and professional obligation and an expression of this broader concept of right to privacy.

G. Privileged Communication

Related to confidentiality and privacy, privileged communication has a narrower meaning and is a legal concept. Privileged communication laws protect clients from having confidential information disclosed in a court of law without their permission (Remley & Herlihy, 2001). State statutes define what kinds of information are privileged and what category of professionals can assert privilege.

H. Protection of Human Participants

In 1977, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was created under the National Research Act of 1974 (Public Law 93-348). Two years later, the Commission published the Belmont Report (1979), which emphasized three ethical principles — autonomy, beneficence, and justice — that must be upheld when conducting research with human participants (Ford, 2001). In 1982, the American Psychological Association published its own guidelines, which have been incorporated into the ACA's Code of Ethics (Ford, 2001; Nugent, 2000).

I. Subpoenas

Subpoenas are official court documents that may require the counselor to:

1. produce copies of records,
2. appear for a deposition, court hearing, or trial, or
3. appear and bring their records with them—"subpoena duces tecum" (Remley & Herlihy, 2001).

The ignoring of a subpoena can result in a charge of contempt of court resulting in the counselor being fined or jailed. The counselor remains responsible to the client for maintaining confidentiality. Therefore, all legal attempts should be made to protect client information. In the event of receiving a subpoena, the counselor should seek legal advice (Remley & Herlihy, 2001).

J. Tort

Tort liability is a civil, rather than criminal, wrong (Huber & Baruth, 1987). A tort is a type of harm done to an individual that requires the person who inflicted the harm to pay damages. Torts may be unintentional, such as in cases of malpractice, or intentional. Intentional torts include battery (unconsented touching of a person), defamation, invasion of privacy, and infliction of mental distress (Huber & Baruth, 1987).

III. Ethical Decision-Making

A. General Principles

The following are six moral principles upon which ethical codes are established and which are involved in ethical decision-making (Remley & Herlihy, 2001; Meara et al., 1996; Kitchener, 1984; Beauchamp & Childress, 1983). Upholding each of these in every situation and balancing them with one another can be a challenge for the counselor.

1. Autonomy

Counselors respect the rights of clients to make their own choices and control their own lives. The ACA guideline states that, “Counselors encourage client growth and development in ways that foster the client’s interest and welfare; counselors avoid fostering dependent counseling relationships” (Standard A.1.b). When applying this principle, counselors should be careful not to impose their own views of individualism but to respect the client’s cultural views of autonomy (Corey, Corey, & Callanan, 2003). With some clients, autonomy can be upheld only to a certain degree (e.g., minors, clients with diminished capacities, etc.).

2. Beneficence

Counselors actively pursue what is good and helpful for their clients. The following ACA guideline addresses beneficence: “The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients” (Standard A.1.a). Determining what is in the client’s best interest can be challenging. The counselor should consider culture, ethnicity, religion, the abilities of their client, and should be cautious about assuming that they know better than the client what is the client’s best interests (Cottone & Tarvydas, 2003).

3. Nonmaleficence

Do no harm. Counselors avoid hurting clients. This is one of the oldest moral principles in the profession and is often considered the most pressing obligation for professionals (Cottone & Tarvydas, 2003). Counselors should be sensitive in the use of assessment, diagnostic, and treatment procedures and be aware of how the results of these actions can affect the client so that distress or discomfort is minimized or avoided (Corey, Corey, & Callanan, 2003; Cottone & Tarvydas, 2003).

4. Justice

Counselors are committed to fairness and are nondiscriminatory and equitable in their treatment of all clients. An important application of justice in the counseling field is equal access. Regardless of age, sex, race, disability, culture, socioeconomic status, religion, or sexual orientation, clients are entitled to equal access to mental health services (Corey, Corey, & Callanan, 2003).

5. Fidelity

The counseling relationship is based on trust. Counselors keep their promises and honor their commitments. The obligation of fidelity extends to such counseling practices as professional disclosure, informed consent, maintenance of confidentiality, misrepresenting or withholding the truth, and avoiding or dealing appropriately with dual/multiple relationships (Cottone & Tarvydas, 2003).

6. Veracity

The counselor is obligated to deal truthfully and honestly with clients. Veracity is one of the means to establish fidelity, or trust, in the relationship. While veracity may be subsumed under fidelity for most writers, a couple of writers distinguish it as a separate principle (see Corey, Corey, & Callanan, 2003; Cottone & Tarvydas (2003).

B. Theories of Ethical Reasoning

The following are the two major philosophical theories of ethical obligation in modern Western thought (Ford, 2001):

- 1. Utilitarianism** is a theory of ethical obligation based on the idea that the rightness or wrongness of an action depends on the goodness or badness of its consequences. In determining the right course of action, what produces the best consequence (most pleasurable or least painful) for the most number of people is the ethical thing to do.
- 2. Formalist Ethical Theory** was developed by the rationalist philosopher Immanuel Kant. The morality of an act is determined formally, that is, by the application of a reasonable principle without any reference to circumstances or consequences of the act. A person can determine whether an action is reasonable (ethical) by applying the test of the “categorical imperative.” The categorical imperative test is the process of viewing an action as a universal moral law. The question to ask oneself is, “if this action was done by everyone (a universal moral law) would a rational person want to live in such a world?” For example, to a formalist thinker, lying under any circumstances is not moral because if lying was a universal moral law then no one could ever trust another person. No rational human being would want to live in such a world.

These two competing theories both find expression in the ethical codes of mental health professions and can thereby produce additional potential for conflict. For example, the principle of respect for the autonomy of persons is a formalist idea—a universal moral law. However, many situations arise in which a counselor must violate this law because of a greater good (a utilitarian idea), e.g., when a person is suicidal or homicidal.

C. Resolving Ethical Issues

When faced with an ethical dilemma, the counselor should look to the principles of autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity cited above. Difficulty in maintaining a principle within a given circumstance or conflict between principles are common sources of ethical dilemmas. Conflict between ethical demands and legal requirements or organizational policies also are common sources of ethical dilemmas.

Awareness of which theory of ethical thinking is most useful in a given situation is important in resolving the dilemma. For most ethical dilemmas, the formalist approach, expressed in the absolute proscriptions of ethical codes, is a good first step in finding a solution. When the ethical code is not clear for a given situation, the counselor should move towards a more critical level of moral thinking in which utilitarian theory is most applicable (Woody, 1990).

A number of models for ethical decision-making have been developed to help the professional decide on the best course of action (Ford, 2001). All of them have the characteristic of first looking to a source of authority (e.g., a code of ethics), and then to the circumstances surrounding the ethical dilemma. *The Practitioners Guide to Ethical Decision Making* (ACA, 1996) suggests the following steps:

1. identify the problem,
2. apply the ACA Code of Ethics,
3. determine the nature and dimensions of the dilemma,
4. generate potential courses of action,
5. consider the potential consequences of all options;
6. choose a course of action,
7. evaluate the selected course of action, and
8. implement the course of action.

Case example: A counselor employed by a mental health agency is working with a 16 yr. old male for substance abuse. The counselor determines that the parents need to be involved in treatment and strongly believes that continued individual treatment is neither effective nor ethical. The agency supervisor instructs the counselor to continue individual counseling regardless of its effectiveness because the client's healthcare policy will not cover family therapy.

The counselor's ethical obligation revolves around her responsibility to the client to provide effective professional services. The ethical code is clear regarding this obligation. The dilemma is providing those services in a context that will not allow enough latitude for the counselor in working with the client.

The ethical code also specifies the responsibility of counselors to work in a professional manner with other professionals. If the counselor refuses to follow instructions, the result could be a reprimand or loss of job. The counselor in this situation would need to consider alternatives, such as contacting the company issuing the healthcare policy to see what could be done in allowing parents to be involved or providing pro bono family therapy. Once alternatives are weighed in terms of the greatest good for the greatest number of people, a course of action is chosen and implemented.

No model of ethical decision-making can tell the counselor what should be done in a given situation. Professionals using the same model for the same set of circumstances might arrive at different conclusions and take different courses of action. A model does not provide answers to ethical problems, but a framework to enable professionals to arrive at their own well-informed, rationally based decisions regarding what to do in a particular circumstance (Ford, 2001).

D. Enforcing Ethical Standards

The ethics committees for state licensing boards and professional organizations have established policies and procedures for enforcing the ethical standards of the profession.

The ACA Ethics Committee is responsible for:

1. Educating the membership as to the Association's Code of Ethics;
2. Periodically reviewing and recommending changes in the Code of Ethics of the Association, as well as Policies and Procedures for Processing Complaints of Ethical Violations;
3. Receiving and processing complaints of alleged violations of the Code of Ethics of the Association; and
4. Receiving and processing requests for interpretations.

The following is a summary of the steps to file an ethical complaint with the American Counseling Association:

1. A written and signed letter outlining the nature of the complaint is sent to the Ethics Committee;
2. The ACA staff liaison to the Committee will communicate in writing with the complainants. Membership status of the person charged is confirmed;
3. The complainant is informed if the person charged is not a member of the ACA;
4. The ACA liaison will assign the complaint to a Co-Chair who will determine if the complaint, if true, would violate the Code of Ethics. If the Co-Chair cannot decide, the complaint will go to the other Co-Chair. If both decide that the complaint would not violate the Code of Ethics, the complaint will not be accepted and the complainant will be informed;
5. If the complaint is accepted, further information may be requested;
6. Complainants must authorize release of information to the charged member;
7. After receiving approval of the Committee Co-Chair, the ACA staff liaison will formulate a formal complaint which identifies all ACA Code of Ethics that may have been violated. A copy of the formal complaint is sent to the complainant to sign and to return. The complainant may add or delete sections of the Code of Ethics in which case the formal complaint is sent back unsigned and a revised formal complaint will be issued for the complainant to sign;
8. All evidence and documents to be considered by the Committee are submitted by the complainants within 30 days of signing the formal complaint.

Chapter 10

Referral/Triage/Advocacy

REFERRAL/TRIAGE/ADVOCACY

NCE – Chapter 10

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REFERRAL/TRIAGE/ADVOCACY

NCE – Chapter 10

CRISIS HISTORY

I. 1942

A. Coconut Grove Nightclub fire

- Occurred in Boston in 1942
- First use of nonprofessionals to provide counseling

B. Eric Lindemann (1944)

- Lindemann published the first major work that focused on crisis intervention
- Focused on the grief reactions experienced by relatives of the victims in the Coconut Grove fire

II. 1946-1964

A. Baby boom; increase in stillbirths, birth defects, and miscarriages

B. The Wellesley project

- Lindemann and Gerald Caplan established a community-wide program of mental health in Cambridge, Massachusetts.
- The focus of this project was on accounts of individual's personal reactions to such traumatic events as sudden bereavement or the birth of a premature child.
- According to Kanel (2003), much of current-day crisis intervention theory has come from the Wellesley project.

III. 1950s

A. Psychotropics were discovered

B. Deinstitutionalization of the mentally ill

IV. 1957

Short-Doyle Act

- This act provided funding for each county throughout the United States to provide mental health clinics.

V. 1960s

- A. Publication of professional journals related to suicide prevention and crisis intervention
- B. Increase in professional studies in psychology and counseling

VI. 1963

- Community Mental Health Centers Act

VII. 1968

Lanterman Petris Short Act

- Established more specific requirements for the provision of mental health services in the community. The focus was to be on short-term crisis intervention when the clients were nonchronic mentally ill patients.

VIII. 1960s – 1970s

- A. Civil rights; grassroots movements; nonprofit agencies; use of paraprofessionals
- B. During this time, *Crisis Intervention* and the *Journal of Life Threatening Behavior* were published.
- C. Evaluations of crisis intervention models demonstrated that they were more effective than long-term psychotherapy.

IX. 1970s – 1980s

- A. Increase in college programs that focused on psychology and counseling
- B. Proliferation of licensed counselors
- C. Movement away from crisis intervention toward traditional mental health counseling

X. 1980s – 1990s

- A. Managed mental health care becomes the standard
- B. Return to crisis intervention in private industry and in community mental health

DEFINITION OF A CRISIS

I. James and Gilliland

“Crisis is a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms” (James and Gilliland, 2001, page 3). This definition is enhanced by the following characteristics and principles of crisis:

- A. A crisis embodies both danger and opportunity for the person experiencing the crisis.
- B. A crisis is usually time limited but may develop into a series of recurring transcrisis points.
- C. A crisis is often complex and difficult to resolve.
- D. The life experiences of crisis and other human services workers may greatly enhance their effectiveness in crisis intervention.
- E. A crisis contains the seeds of growth and impetus for change.
- F. Panaceas or quick fixes may not be applicable to many crisis situations.
- G. A crisis confronts people with choices.
- H. Emotional disequilibrium and disorganization accompany crisis.
- I. The resolution of crisis and the personhood of crisis workers interrelate.

II. Meyer

Meyer (2001) elaborates on James and Gilliland’s definition by stating that “the crisis must be viewed from the client’s perspective, not the crisis worker’s....

- A. A crisis is a reaction to a specific event or situation;
- B. A crisis event must be understood by clients as unbearable; and
- C. Client’s must believe they do not have the resources immediately available to prevail over the situation (pages 3-4).”

III. Aguilera

Aguilera (1998) defines crisis as “A psychological crisis refers to an individual’s inability to solve a problem (page 1).”

IV. Kanel

Kanel (2003, page 1) refers to the **trilogy definition** of crisis and states, “the three aspects of a crisis are these:

- A. A precipitating event occurs;
- B. The perception of this event leads to subjective distress; and
- C. Usual coping methods fail, leading the person experiencing the event to function psychologically, emotionally, or behaviorally at a lower level than before the precipitating event occurred.”

CRISIS DEVELOPMENT

I. Four Stages of Development

According to Marino (1995, page 25), “Crisis development occurs in four distinct stages:

- A. A critical situation occurs in which a determination is made as to whether a person’s normal coping mechanisms will suffice;
- B. Increased tension and disorganization surrounding the event escalate beyond the person’s coping ability;
- C. A demand for additional resources (such as counseling) to resolve the event is needed;
- D. A referral may be required to resolve major personality disorganization.”

II. A Response Condition

A crisis may be thought of as a response condition wherein:

- A. Psychological homeostasis has been disrupted.
- B. One’s usual coping mechanisms have failed to re-establish homeostasis.
- C. The distress engendered by the crisis has yielded some evidence of functional impairment.

DIFFERENCES IN CRISIS AND PSYCHOTHERAPY

I. Length of Treatment

A. Crisis

- Crisis intervention is time-limited with a duration of not more than six weeks.
- A client may be seen once or several times within this limited time span.

B. Traditional Psychotherapy

- Treatment may be extended for weeks, months, or years
- A client most typically would be seen on a weekly or a bi-weekly basis until the issues that the client presented were resolved.

II. Purpose of Treatment

A. Crisis

- Crisis treatment addresses a specific issue and attempts to help clients resolve only that concern.

B. Traditional Psychotherapy

- Psychotherapy addresses multiple cognitive, behavioral, and personality issues.

III. Treatment Dimension

A. Crisis

- Crisis treatment focuses on clients returning to a precrisis level of functioning.

B. Traditional Psychotherapy

- Psychotherapy attempts to make changes in the personality, behavioral, or cognitive functioning of the client.

TYPES OF CRISES

I. Developmental Crises

- “Events that are commonly experienced in growth and maturation (Aguilera, 1998, page 1).”

II. Situational Crises

- Events that occur unexpectedly during the course of a person’s life
- These crises are usually sudden and cannot be controlled

III. Existential Crises

- Includes the anxieties that accompany human issues of purpose, responsibility, independence, freedom, and commitment

IV. Environmental Crises

- Occur when some natural or human-caused disaster overwhelms a person or group of people who are inundated in the aftermath of an event that may affect almost every member of the community in which they live.
- Examples might be hurricanes, floods, earthquakes, etc.

CRISIS ASSESSMENT MODELS

I. Psychoanalytic Theory

- A. This theory postulates that the disequilibrium that accompanies a person's crisis can be understood through gaining access to the individual's unconscious thoughts and past emotional experiences.
- B. This theory maintains that an early childhood fixation is the primary reason an event becomes a crisis.

II. Existential Theory

- A. This theory holds that anxiety is a normal part of human existence and can help self-development.
- B. Anxiety is seen as a motivator to risk and to grow.
- C. The individual needs to take personal responsibility for his/her circumstances and realize that many problems are self-caused.

III. Humanistic Theory

- A. Humanistic Theory stresses the importance of clients being able to realize their potential in the context of a therapeutic relationship.
- B. Crises are seen as blocks to growth and potential for growth.
- C. The counselor's being "present" with the client helps the client to begin to accept himself/herself, trust in himself/herself, and make more appropriate choices based on this self-acceptance and trust.
- D. The outcome goal is to return the power of self-evaluation to the individual. This will enable the person in crisis to once again control his or her own destiny and regain the ability to take whatever action is needed to cope with the crisis situation.

IV. Cognitive-Behavioral Theory

- A. Cognitive theories emphasize the importance of understanding the crisis from the client's cognitive view of the problem, and then reframing the maladaptive approaches/ideas of the client towards a more beneficial and productive way of viewing the crisis.
- B. Behaviorists' tend to follow the basic six step process of:
 - 1. defining the problem
 - 2. reviewing what has been tried to correct the problem in the past
 - 3. deciding what the client wants when the problems have been resolved
 - 4. brainstorming alternatives
 - 5. selecting alternatives and committing to following through with them
 - 6. follow-up by the crisis worker to determine the effectiveness of the process

V. Systems Theory

- A. This theory is based not so much on what happens to the individual or his/her perception of the problem(s) as what happens within the interrelationship and interdependence among and between people and events.
- B. Kanel (2003) uses the term "runaway" to describe a true family crisis. A runaway exists when the counteractive/negative feedback mechanisms fail to bring the situation back into calibration – that is, family members cannot create homeostasis by normal coping mechanisms.

VI. Brief Theory

- A. In Brief Theory, the client is encouraged to explore his/her past patterns of behavior and how these have prevented him/her from succeeding at life the way he/she has wanted to succeed.
- B. Focus is on creative change and incorporating new styles of relating to the world.

VII. Adaptational Theory

- A. Adaptational Theory depicts a person's crisis as being sustained through maladaptive behaviors, negative thoughts, and destructive defense mechanisms.
- B. This theory is based on the premise that the person's crisis will recede when the maladaptive coping behaviors are changed to adaptive behaviors.
- C. Aided by the crisis interventionist, the client may be taught to replace old, incapacitating behaviors with new, self-enhancing ones.
- D. Such new behaviors may be applied directly to the context of the crisis and ultimately result in either success or reinforcement for the client in overcoming the dysfunctional behavior.

VIII. Chaos Theory

- A. Chaos Theory states that even though a crisis may appear to epitomize an insoluble and chaotic impasse, careful examination of such chaos may actually reveal the key to understanding an important, profound, and hitherto unrecognized, global message.
- B. The recognition of this message can provide both the impetus and the motivation needed to initiate positive or purposeful action toward alleviating the dilemma.

IX. Eclectic Crisis Intervention

- A. This theory involves intentionally and systematically selecting and integrating valid concepts and strategies from all available approaches to helping clients.
- B. Eclecticism is a hybrid of all available approaches and operates from a task orientation as opposed to concepts.
- C. In this approach the crisis interventionist is not locked into one theoretical approach but rather is well versed in a number of approaches and theories. Being thus prepared, the crisis worker can assess the client's needs and select techniques appropriate to the situation.

X. Hoff Model

- A. The Hoff Model can best be described as a “vulnerability model.”
- B. To assess vulnerability, crisis workers must consider three elements:
 - 1. the hazardous event
 - 2. the precipitating factor
 - 3. the person’s reaction
- C. Hoff suggests that these signals may be affective, cognitive, or behavioral and must be differentiated from distorted perceptions or mental illness.

XI. Slaikeu Model

- A. The Slaikeu Model proposes a multidimensional assessment of the affective, behavioral, physical, and cognitive aspects of crisis reactions.
- B. This model modifies Lazarus’ BASIC-ID assessment approach by:
 - categorizing substance abuse as behavioral rather than in a separate category
 - characterizing all physical functioning factors as somatic functioning
 - combining the imagery and cognitive dimensions into one category

XII. Hendricks and McKean Model

- A. This model proposes a “frontline model” for assessment in crisis intervention for use on the streets.
- B. According to Hendricks and McKean, the assessment process involves two phases:
 - 1. Securing the scene
 - These authors suggest using the “who, what, when, where, and why” as a strategy to get the needed information to intervene.
 - 2. Evaluating the person in crisis
 - The second phase involves evaluating the person in crisis, determining his/her level of functioning, and getting information regarding his/her medical and psychiatric history.

XIII. ABC Model of Crisis Intervention

- A. Kanel (2003) extrapolated and added to Jones' (1968) [not covered here] model to propose the A-B-C model of Crisis Intervention.
- B. This model organizes a crisis interviewing session that can be used effectively in a ten-minute phone interview, in one session, or in six sessions.
- C. Kanel (2003, page 26) states, "this crisis intervention model is an action-oriented effort between a helper and a person immobilized by an emergency situation; the purpose is to provide temporary, but immediate, relief."
- D. As with most theories, the goal is to help the client integrate the precipitating event into his or her daily functioning and to return to pre-crisis levels emotionally, occupationally, and interpersonally.

STAGE "A"

- Stands for developing and maintaining contact
- This includes rapport building by developing basic attending skills which is the underpinning of the therapeutic encounter.
- It is believed that if the client does not make contact with the crisis worker, who is recognized as possessing the core counseling skills, the client cannot move on to steps B and C.

STAGE "B"

- Identifying the problem and therapeutic interaction is the second step, B.
- Due to the fact that crisis intervention is time limited, it is important for the counselor to get directly to the reason that the client is seeking help at this particular time.
- This is held to be the most important step in crisis intervention by Kanel.

STAGE "C"

- C is the final step in crisis intervention and assists the client in taking charge of his/her behavior so that he/she learns to cope with the crisis and can return to a pre-crisis level of functioning.

XIV. Triage Assessment Form (TAF)

- A. This model assumes that it is necessary to assess crisis reactions in three different domains: **affective, cognitive, and behavioral.**
- B. Each domain is divided into three types of responses that represent the range of reactions a client might experience during a crisis situation.
- C. The **affective domain** includes:
 - 1. anger/hostility
 - 2. anxiety/fear
 - 3. sadness/melancholy
- D. The **cognitive domain** includes:
 - 1. perception of a transgression
 - 2. threat
 - 3. loss
- E. The **behavioral domain** includes:
 - 1. approach
 - 2. avoidance
 - 3. immobility

XV. Six-Step Model of Crisis Intervention

- A. James & Gilliland (2001) offer a Six-Step Model of Crisis Intervention.
- B. The over-arching concept of all of the steps in this model is continual assessing of the client and the situation.
- C. The six steps are divided into two sections: **listening** and **acting**.
 - 1. The three steps under **listening** are:
 - a. define the problem
 - b. insure client safety
 - c. provide support
 - 2. The three steps under **acting** include:
 - a. examine alternatives
 - b. make a plan
 - c. obtain commitment

CHARACTERISTICS OF EFFECTIVE CRISIS WORKERS

I. Life Experiences

- One who has experienced life, has learned and grown from those experiences, and has supported those experiences in his or her work by thorough training, knowledge, and supervision.

II. Professional Skills

- A. Attentiveness
- B. Accurate listening and responding
- C. Congruence between thinking, feeling, and acting therapeutically
- D. Reassuring and supporting skills
- E. Rudimentary ability to analyze, to synthesize, and to diagnose
- F. Basic assessment and referral skills
- G. Ability to explore alternatives and to solve problems

III. Poise

- Creating a stable and rational atmosphere provides a model for the client that is conducive to restoring equilibrium to the situation.

IV. Creativity and Flexibility

- The ability to use the skills one has in ways that are adaptable to clients' needs

V. Energy

- “Functioning in the unknown areas that are characteristic of crisis intervention requires energy, organization, direction, and systematic action” (Carkhuff & Berenson, 1977, page 194).

VI. Quick Mental Reflexes

- The crisis worker must have fast mental reflexes to deal with the constantly emerging and changing issues that occur in the crisis.

VII. Other Characteristics/Attributes

The following characteristics are listed in the literature as necessary for effective crisis workers:

- Tenacity
- The ability to delay gratification
- Courage
- Optimism
- A reality orientation
- Calmness under duress
- Objectivity
- A strong and positive self-concept

STEPS IN CRISIS INTERVENTION

I. Assessment

- A. Assess the individual and his/her problem
- B. Determine what situation brought the individual to seek professional help
- C. Assess whether the client represents a suicidal or homicidal threat
- D. Refer to psychiatrist for consideration of hospitalization if dangerous to self or others
- E. Proceed with intervention if hospitalization is not considered necessary

II. Planning Therapeutic Intervention

- A. The goal is to bring the client back to at least the pre-crisis level of equilibrium.
- B. Determine the length of time that has passed since the crisis. (The precipitating event usually occurs from one to two weeks before the individual seeks help.)
- C. Assess the amount of disruption that has occurred in the client's life and the effects of this disruption on others in his/her environment.
- D. Determine the client's strengths.
- E. Assess the coping skills the client may have used successfully in the past.
- F. Assess the client's support system.

III. Intervention

The nature of intervention techniques is highly dependent on the pre-existing skills, creativity, and flexibility of the counselor.

- A. The counselor aims to help the individual gain an intellectual understanding of his/her crisis.
- B. The counselor attempts to help the individual become aware of his/her present feelings. An immediate aim of the intervention is the reduction of tension by giving the individual a way to recognize these feelings and bring them into the open.
- C. The counselor explores the client's current coping mechanisms. The intent of this intervention is to help the client explore new and/or alternate ways of coping.
- D. The counselor works to reopen the client's social world. This involves getting the client back in touch with his/her social system or assisting and encouraging the client to develop a new network.

IV. Resolution of the Crisis and Anticipatory Planning

- A. The counselor reinforces adaptive coping mechanisms.
- B. The counselor and client make realistic plans for the future.
- C. The client is encouraged to assess how he/she might handle a similar crisis in the future.

CATEGORIES OF CRISIS INTERVENTION

(Mitchell & Everly, 2001)

I. Demobilization

- A. Mitchell and Everly (2001, page 12) refer to demobilization as a quick informational and rest session.
 - 1. Typically, demobilization occurs when operations units have been released from service at a major incident that requires over 100 personnel.
 - 2. Demobilization also functions as a screening opportunity to assure that individuals who may need assistance are identified after the traumatic event.
 - 3. Demobilizations are rare and are generally reserved for large-scale incidents such as disasters.
- B. Goals of Demobilization
 - 1. Assess well-being of personnel after major incident
 - 2. Mitigate impact of event
 - 3. Provide stress management information to personnel
 - 4. Provide an opportunity for rest and food before returning to routine duties
 - 5. Assess the need for debriefing and other services

II. Crisis Management Briefing (CMB)

- A. Used with large groups of primary victims
- B. Goals of Crisis Management Briefing
 - 1. Provide information
 - 2. Rumor control
 - 3. Reduce sense of chaos
 - 4. Provide coping resources
 - 5. Facilitate follow-up care
 - 6. Engender increased cohesion and morale
 - 7. Assess further needs of group
 - 8. Restore personnel to adaptive functions

III. Defusing

Defusing is similar to debriefing but is shorter in length, averaging only about 20 to 45 minutes.

A. Defusing components include:

1. Introduction
2. Exploration
3. Information

B. Goals of Defusing

1. Mitigate the impact of the event
2. Accelerate the recovery process
3. Assess the need for debriefings and other services
4. Reduce cognitive, emotional, and physiological symptoms

IV. Critical Incident Stress Debriefing (CISD)

CISD is a group of meetings or discussions about a traumatic event or a series of traumatic events. CISD may last from one to two hours.

A. Stages of CISD:

1. Introduction
2. Facts
3. Thoughts
4. Reactions
5. Symptoms
6. Teaching
7. Re-Entry

B. Goals of CISD

1. Mitigate the psychological impact of a traumatic event
2. Prevent the development of a posttraumatic syndrome
3. Assess for individuals who will require professional mental health follow-up subsequent to the traumatic event

GENERAL PRINCIPLES OF CRISIS INTERVENTION

I. Crisis Intervention Basic Principles

- A. Jacobson, Strickler, & Mosley (1968) state, “While there is no one single model of crisis intervention, there is common agreement on the general principles to be employed by Emergency Mental Health (EMH) practitioners to alleviate the acute distress of victims, to restore independent functioning and to prevent or mitigate the aftermath of psychological trauma and PTSD.”
- B. The following are steps in Crisis Intervention:
 - 1. **Intervene** immediately
 - 2. **Stabilize** the victims or the victim community by actively mobilizing resources and support networks to restore some semblance of order and routine. The early stabilization of the victims provides the tools for the victim to function independently.
 - 3. **Facilitate understanding** in order to assist the client to pre-crisis functioning.
 - 4. **Focus on problem-solving** by helping the client solve problems within the context of what he/she feels is possible so as to enhance independent functioning.
 - 5. **Encourage self-reliance** as an additional means to restore independent functioning.

II. Five Main Goals of Crisis Interventions

- A. Stabilization and safety of victim
- B. Mitigation of stress
- C. Mobilization of resources
- D. Normalization of feelings
- E. Restoration to function

III. Crisis Intervention is Support, not Psychotherapy

IV. Fundamental Principles of Crisis Intervention

- A. Simplicity
- B. Brevity
- C. Pragmatism
- D. Innovative
- E. Proximity
- F. Immediacy
- G. Expectancy

REFERRAL RESOURCES

I. List of Referral Resources

An important part of the Crisis Worker's responsibility is to have a list of referral resources, including:

- A. phone numbers
- B. names
- C. contact people

II. Suggestions for Crisis Workers

James and Gilliland (2001) offered the following suggestions:

- A. Keep an up-to-date list of frequently used agencies. Keep up with personnel changes.
- B. In communities that publish a directory of human services, have available the most recent edition.
- C. Cultivate a working relationship with key people in agencies you frequently use.
- D. Follow-up on referrals you make.
- E. Don't assume that all clients have the skill to get the services they need.
- F. Be prepared to assist in order to avoid run-around and bureaucratic red tape.
- G. Be sensitive to the client's needs for transportation and child care.
- H. Keep accurate records of referral activities.
- I. Be aware of any agency the client is already using.
- J. Use courtesy and good human relations skills when dealing with agency personnel.
- K. Put yourself in your client's shoes and treat them as you would want to be treated.
- L. Give agencies feedback on how they did; obtain feedback from them too.
- M. Be aware of sensory impairment in clients, especially in older adults, and make those impairments known in referrals.
- N. If the client can do so, it is a good idea for the client to make the call (this creates a personal link between the client and the referral agency).
- O. Practice honesty in communicating to referral agencies regarding the status or the needs of clients.
- P. Obtain permission of the client before attempting to refer.
- Q. Observe rules of confidentiality and rights of privacy in regard to all clients and fellow workers.

ADVOCACY ISSUES IN CRISIS COUNSELING

- I. Advocacy is defined as action taken by a counseling professional to facilitate the removal of external and institutional barriers to a client's well-being. Advocacy "serves two primary purposes:
 - A. increasing client's sense of personal power and
 - B. fostering environmental changes that reflect greater responsiveness to his/her personal needs (Lewis and Bradley, 2000, page 172)."
- II. Effective crisis workers are required to get out into the community and to know personally the key individuals who can provide the kinds of assistance your client needs.
- III. Appropriate advocacy requires collaboration on the part of the counselor and client.
- IV. Advocacy is a process which defuses prejudice and attempts to redefine power by redistribution, thus allowing for greater access for all.
- V. The following are groups for which the crisis worker can advocate:
 - A. African-American clients
 - B. Native American Indian and Alaska Native clients
 - C. Latino/Latina clients
 - D. Multiracial families
 - E. Youth
 - F. Older adults
 - G. Lesbian, Bisexual, Gay, and Transgendered persons
 - H. Gender
 - I. Domestic violence victims
 - J. People with HIV/AIDS
 - K. Mentally ill people
 - L. Homeless individuals

MULTICULTURAL PERSPECTIVES IN CRISIS INTERVENTION

- I. Kiselica (1998:6) identifies four attributes that are widely accepted as characteristics needed in crisis workers and other helping professionals who intervene with clients in the multicultural world in which we work:
 - A. Self knowledge, particularly an awareness of one's own cultural biases
 - B. Knowledge about the status and cultures of different cultural groups
 - C. Skills to effect culturally appropriate interventions, including a readiness to use alternative strategies that more closely match the cultures of crisis clients than do traditional strategies
 - D. Actual experience in counseling and crisis intervention with culturally different clients
- II. Unintentional and unexamined cultural and racial assumptions can impair the functioning of counselors and crisis workers.
- III. A multicultural perspective in the thought processes, emotional attitudes, and behaviors of crisis workers can go a long way toward eliminating the negative effects of institutionalized racism, ethnocentrism, ageism, religionism, homophobia, able-bodied-ism, sexism, and other forms of cultural and personal bias that clients may encounter in some crisis agencies.
- IV. Counselors should be aware of their own assumptions, values, and biases regarding racial, cultural, and group differences before considering individual variations on those themes.
- V. It is of utmost importance that the recruitment, screening, orientation, training, evaluation, and retention of crisis workers deal with the realities of a multicultural clientele.
- VI. Multicultural helping is enhanced when crisis workers use methods and goals that are consistent with the life experiences and cultural values of clients.

- VII. Kanel suggests four stages of development in becoming a multiculturally sensitive counselor:
- A. Stage One
 - Counselor is unaware of cultural issues
 - Does not take into consideration an individual's cultural, ethnic, religious background as related to the problem
 - B. Stage Two
 - Counselor develops heightened awareness of cultural issues but feels unprepared to utilize this knowledge with a client
 - C. Stage Three
 - Counselor feels the burden of considering culture
 - Able to utilize knowledge of cultural diversity but feels overwhelmed with the task and how to implement
 - Perceives all problems as relating to culture
 - D. Stage Four
 - Counselor moves toward cultural sensitivity
 - Able to be sensitive to cultural diversity yet also able to view problems as universal issues as well
- VIII. Cormier and Hackney (1987) postulate the following strategies that culturally effective helpers use:
- A. Examine and understand the world from the client's viewpoint
 - B. Search for alternative roles that may be more appealing and adaptive to clients from different backgrounds
 - C. Help clients from other cultures make contact with and elicit help from indigenous support systems
- IX. Cormier and Hackney (1987) specify that to be culturally effective, helpers should **not**:
- A. Impose their values and expectations on clients from different backgrounds
 - B. Stereotype or label clients, client behaviors, or cultures
 - C. Try to force unimodal counseling approaches upon clients

LEGAL & ETHICAL ISSUES IN CRISIS COUNSELING

- I. Strong ethical practice is especially important in the field of crisis intervention because clients in crisis come to the crisis worker in a vulnerable state of disequilibrium and instability.
- II. Confidentiality is the counselor's ethical obligation to safeguard patient communications. Confidentiality is a general ethical duty, a feature of many professional organizations' codes of ethics, and a component of many licensing and certifying agencies' regulations.
- III. Privilege constitutes the particular legal rights that state law gives to patients. "Privilege is a legal right belonging to the patient." In most states, the counselor's general duty of confidentiality must give way when disclosure is necessary to warn or to prevent harm to an identifiable third party.
- IV. A "disclosure statement" is a written document detailing the policy, negotiated between the counselor and patient, concerning counselor disclosure of patient information.
- V. Clients may be asked to waive privilege to assure continuity of care among mental health professionals, to provide for appropriate supervision when access to records is needed for court testimony, and to submit the information, if necessary, for health insurance claims.
- VI. Ethical standards may closely parallel the law, but they do not have the weight of the law. Ethical codes are general guiding codes of conduct for a particular profession.
- VII. When counselors are providing crisis intervention to a client, they should not be involved with that client on a personal level of any kind. This includes prohibition of any relationship that is not directly related to the provision of crisis intervention including: sexual, social, employee, or financial.
- VIII. The counselor is responsible for reporting elder abuse if any of the following acts are inflicted on an elder by another person, other than by accidental means: physical abuse, fiduciary abuse, neglect, and/or abandonment.
- IX. The reporting of child abuse is a requirement if the counselor perceives (or has a suspicion) that there has been physical abuse, sexual abuse, general neglect, or emotional abuse.

APPLICATIONS OF CRISIS INTERVENTION

Crisis intervention can be applied to any situation in which the definition of “crisis” has been met and includes all of the following:

- Posttraumatic Stress Disorder
- Suicide
- Rape
- Sexual abuse of a child
- Sexual abuse in families
- Date and acquaintance rape
- Partner violence
- Chemical dependency
- Personal loss, bereavement, and grief
- Violent behavior in institutions
- Violent behavior in society
- Crises in schools
- Hostage crises
- Persons with AIDS/HIV
- Burnout in professional counselors/crisis intervention workers
- Physical problems
- Earthquake
- Hurricane
- Fires
- Flood
- Large scale environmental pollution
- Multiple injury/fatality accidents
- Terrorism
- Child related traumatic events
- Homicides in the community
- Community wide disasters

Chapter 11

Supervision

SUPERVISION

NCE – Chapter 11

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SUPERVISION

NCE – Chapter 11

DEFINING THE TERM

I. Supervision Defined

- A. Supervision involves a professional relationship in which the competencies of the supervisee are identified, developed, and evaluated by a more experienced professional in the field.
- B. Bernard and Goodyear (1998) define supervision as "an intervention provided by a more senior member of a profession to a more junior member or members of that same profession" (p. 4).
- C. Supervision is both a professional and a legal issue.
- D. State licensure laws ensure that a novice in the counseling field will receive adequate supervision during his/her graduate education as well as post degree.
- E. Supervision is essential both in the preparation of competent mental health professionals and in the protection of the welfare of clients.

Supervision provides the means to blend formal theory with the knowledge and skills of the practitioner (Bernard & Goodyear, 1998). Essential to the training of competent professionals is the ability to integrate what is learned in the classroom with what occurs in the counseling room. Clinical skills are not acquired simply through exposure to clinical experience. The experience must be accompanied by systematic feedback and reflection within an ongoing relationship in which a supervisor challenges, stimulates, and encourages the supervisee (Bradley & Ladany, 2001; Bernard & Goodyear, 1998). The supervisor is expected to be a competent professional who is able to help the supervisee by means of a clearer vantage point or "super-vision" (Bradley & Ladany, 2001; Bernard & Goodyear, 1998).

II. Purposes of Supervision

The purposes of supervision can be summarized by the following:

- A. Prepare competent professionals
- B. Protect the welfare of clients by monitoring the quality of services provided to them
- C. Rehabilitate impaired professionals
- D. Provide personal and professional development
- E. Evaluate the fitness of the supervisee as a gate keeping function of the profession (Bradley & Ladany, 2001; Remley & Herlihy, 2001; Bernard & Goodyear, 1998; Corey, Corey, & Callanan, 1998)

III. Two Types of Supervision

Two types of supervision are recognized in the literature: (Remley & Herlihy, 2001; Bernard & Ladany, 2001; Borders and Leddick, 1987).

A. Clinical Supervision

1. Clinical supervision focuses on the work of the supervisee with his or her clients.
2. Areas to be examined in clinical supervision include (Remley & Herlihy, 2001; Bernard & Ladany, 2001; Borders and Leddick, 1987):
 - Client welfare
 - The counseling relationship
 - Assessment
 - Diagnosis
 - Intervention
 - Prognosis
 - Referral procedures

B. Administrative Supervision

1. The focus of administrative supervision is on how the supervisee is performing his or her job as a member of the organization.
2. Areas of focus in administrative supervision include (Remley & Herlihy, 2001; Bradley & Ladany, 2001; Borders and Leddick, 1987):
 - Case records
 - Referrals
 - Performance evaluations
 - Anything else that impacts organizational functioning
3. Sometimes a supervisor will provide both administrative and clinical supervision to the same supervisee.

MODELS OF SUPERVISION

Models of supervision are often derived from theories of psychotherapy. Models specific to supervision, namely developmental models, as well as a number of integrative approaches have been developed (Holloway, 1995). The following are selected counseling-derived models as well as developmental approaches to supervision.

I. Psychodynamic Supervision

A. Three Perspectives of Supervision

Bernard and Goodyear (1998) describe two competing views that arose in the 1930's over "control analysis" (supervision).

1. **One group emphasized** supervision as an extension of the supervisee's ongoing personal analysis with emphasis on transference with clients and countertransference with supervisors.
2. **The other group maintained** that issues of transference and countertransference should be addressed in personal analysis, while supervision should emphasize didactic teaching.
3. **The contemporary form of the psychodynamic model emphasizes** teaching and the relationship processes between patient, counselor, and supervisor (Bradley & Ladany, 2001; Bernard & Goodyear, 1998). Interpersonal dynamics, intrapersonal dynamics, and parallel processes are somewhat overlapping key concepts to this model of supervision.

B. Interpersonal Dynamics

1. Important to the psychodynamic model of supervision are the interpersonal dynamics occurring between supervisee and client and the supervisor and supervisee. The dynamics between supervisee and client are considered of primary importance (Bradley & Ladany, 2001).
2. The supervisor teaches the supervisee how to deal with interpersonal dynamics effectively by modeling an "analytic attitude" with the supervisee (Moldawsky, 1980, p.126).
3. The supervisee is expected to communicate in ways that are beneficial to the client.

C. Intrapersonal Dynamics

1. Intrapersonal dynamics include the behaviors, feelings, thoughts, perceptions, attitudes, and beliefs of the supervisee as they relate to the supervisee-client relationship.
2. The supervisor helps the supervisee understand how these internalized responses influence his or her overt behaviors (Bradley & Ladany, 2001).
3. A criticism of the psychodynamic model relates to the danger of focusing so much on the intrapersonal dynamics of the supervisee that supervision becomes counseling (Bradley & Ladany, 2001).

D. Parallel Processes

Parallel processes, the idea that similar interpersonal dynamics occur in both the supervisee-client dyad and the supervisor-supervisee dyad, are often used for teaching and learning by psychodynamically oriented supervisors.

1. Researchers vary in their belief regarding the primary direction of the flow of influence.
 - a. If conflict occurs in the supervisory relationship, it can impact the supervisee-client relationship.
 - b. The interpersonal dynamics existing in the supervisee-client relationship can flow into the supervisor-supervisee dyad (Binder and Strup, 1997; Williams, 1995; Doerhman, 1976; Ekstein and Wallerstein, 1972).
2. The idea of parallel processes is no longer exclusive to the psychodynamic orientation but is acknowledged across many models of supervision.

II. Cognitive-Behavioral Supervision

The cognitive-behavioral model of supervision is based on:

- A. Learning theory with its emphasis on conditioning
- B. Cognitive theory with its emphasis on cognitions and perceptions of the supervisee.
 - 1. Behaviorally-oriented
 - The more behaviorally-oriented supervisor would focus on the specific learned skills (behaviorally defined and measurable) of the supervisee and on creation of a learning environment by employing the principles of learning theory (e.g., teach appropriate counselor behavior and extinguish inappropriate behavior) within the procedures of supervision (Bernard & Goodyear, 2001).
 - 2. Cognitively-oriented
 - The more cognitively-oriented supervisor would emphasize identifying the supervisee's self-talk (or internal dialogue) and challenging the supervisee's cognitions and misperceptions (Bernard & Goodyear, 2001).

III. Person-Centered Supervision

Person-centered supervision, based on Carl Rogers' model of counseling, incorporates elements of teaching and counseling.

A. Teaching

- Bernard and Goodyear (1998) report that Rogers, who was one of the first to use electronically recorded interviews and transcripts for supervision, was convinced that didactic training was insufficient.

B. Counseling

- The supervisee needs to have access to what actually transpired in the counseling interview.
- However, Rogers also emphasized the process of supervision as actually being a modified form of counseling.
- In addition to expressing to the supervisee how he would have interviewed the client, Rogers believed that the facilitative conditions of genuineness, warmth, empathy, etc., were necessary for both clients and trainees (Bernard & Goodyear, 2001; Hackney and Goodyear, 1984).

IV. Systemic Supervision

A. Interlocking Family and Supervisory Systems

1. Systemic supervision (which is virtually synonymous with family therapy supervision) focuses on the interlocking family and supervisory systems.
2. The emphasis of this model is on what the supervisor does in supervision rather than what he or she thinks about supervision.
 - The supervisory relationship is seen as a dynamic process in which personal interactions are conducted within a structure of power and involvement in the supervisee's training.
3. The relational structure needs to be sufficiently flexible to accommodate the supervisee's development and learning style (Holloway, 1995).

B. Contextual Factors

1. Contextual factors are continually evaluated in terms of their impact on the supervisory relationship (Bradley & Ladany, 2001).
2. Contextual factors include the supervisor, supervisee, client, and institution.
 - Each of these factors interacts and interrelates in relationship to the other.
 - For example, an agency will have specific rules, policies, procedures, and politics that will affect clientele, organizational structure and climate, and professional ethics and standards.
 - The context of that institution will largely influence the supervisor's work with the supervisee.

C. Isomorphism

1. A systemic reworking of the idea of parallel process is called isomorphism.
 - For systems therapists, isomorphism refers to the constant influence between therapy and supervision.
2. The influence is interrelational rather than intrapsychic (Bernard & Goodyear, 1998).
 - The focus is on the repeating patterns of interaction rather than content.
3. Isomorphism is both a descriptive concept as well as a prescriptive one.
 - In other words, the systemic supervisor utilizes isomorphic patterns as a way to assess what is actually happening in the relationship of supervisee and client and as a means to enable the supervisee to intervene in that relationship.
 - For example, Haley (1987) illustrates that if the goal is for the parents to be firm with the teenager, the therapist needs to be firm with the parents. Likewise, the supervisor will need to be firm with the supervisee. In this example, if the supervisor is unwilling to take a stand on the issue of parental authority, the supervisee will have a difficult time empowering the parents to take charge of the teenager.

V. Narrative Supervision

A. Postmodern or Social Constructionism

1. A recent theoretical development has been the emergence of a worldview referred to as "postmodern" or "social constructionism."
2. These two terms are not exactly synonymous; however, they both refer to the position that reality and truth are created, or constructed, through social interactions.
3. Specifically, the language that is used creates the context for meaning.

B. Narrative

1. The "postmodern/social constructionism" worldview has been applied by some in the mental health field to the conceptualization of the therapeutic process (Bradley & Ladany, 2001).
 - The narrative approach to therapy is one example.
2. Counselors who work from this perspective view people as storytellers who develop a story about their lives that serves to organize past and present experiences and influences current behavior.
3. The counselor encourages the client to tell his or her story and serves as an editor.
 - The counselor does not "violate" the story by taking a hierarchical or expert position with the client or by imposing outside ideas or a particular point of view.
 - Rather, the counselor asks questions that serve to help the client re-write his/her story.

C. Narrative Supervisors

1. Narrative supervisors attempt to assist trainees in helping clients re-write their stories as well as helping the trainee develop and revise his/her own professional story (Bradley & Ladany, 2001).
2. Supervision from this perspective has created some difficulties.
 - If the narrative supervisor intends to supervise in a way that is consistent with this viewpoint, how does he or she take the position as an expert responsible for a trainee?
 - Various methods have been used to address this and other issues, including the use of "reflective teams."

VI. Developmental Approaches to Supervision

Developmental approaches to supervision are not based on psychotherapy models but rather focus on the changes that supervisees undergo as they gain experience and training (Bernard & Goodyear, 1998).

These approaches address both the development of the counselor through stages as well as how the supervisor should work in light of that development.

Bernard and Ladany (2001) emphasize a distinction between **organismic development** and **mechanistic development**.

1. **Organismic development** refers to a holistic view of the overall transformation into a professional as changes occur in how the counselor interprets and uses knowledge.
2. **Mechanistic development** refers simply to the acquisition of new knowledge and skills.

Both of these types of development occur in conjunction with each other.

The literature on the developmental approaches to supervision is organized in various ways. Borders (1986) suggests dividing developmental models into those that:

1. focus on the role of the supervisor
2. focus on the dynamics of the trainee
3. focus on the learning environment of supervision

Several specific **developmental models** are categorized under the Developmental model (Bernard and Goodyear, 1998).

A. The Littrell, Lee-Borden, and Lorenz Model - four stage model:

Stage 1: Relationship-building, goal-setting, and contracting

Stage 2: Emphasis of the supervisor on teaching and helping the counselor deal with affective issues and skill deficits

Stage 3: The supervisor adopts a more collegial role

Stage 4: The supervisee takes responsibility for his or her learning, and the supervisor becomes more of a consultant

B. The Stoltenberg Model - four levels:

Level 1 – Supervisee is very dependent.

- Limited autonomy should be encouraged.

Level 2 – Characterized by dependency-autonomy conflict.

- The supervisor should offer less structure and instruction.

Level 3 – Characterized by conditional dependency.

- The supervisor should treat the supervisee as a peer.

Level 4 – The master counselor.

- Supervision, if continued, becomes collegial.

C. The Logenbill, Hardy, and Delworth Model

1. Emphasizes eight professional issues:

- competence
- emotional awareness
- autonomy
- identity
- respect for individual differences
- purpose and direction
- personal motivation
- professional ethics

2. Emphasizes three levels:

- stagnation
- confusion
- integration

THE SUPERVISORY RELATIONSHIP

Supervision is an intervention distinct from education, counseling, or consultation.

I. Supervision vs. Education

- A. Supervision is distinct from education in that education typically includes an explicit curriculum with goals that are uniformly imposed on every learner.
- B. Supervision must be tailored to the needs of the individual supervisee and to the supervisee's clients (Bernard and Goodyear, 1998).

II. Supervision vs. Counseling

Supervision is distinct from counseling in at least two ways (although the supervisee may examine his/her thoughts and feelings toward his/her client(s) as it directly relates to providing competent professional service):

- A. Clients have a choice of whether or not to attend counseling and who their counselor will be.
 - Supervisees do not have a choice about supervision and very often do not have a choice of supervisors.
- B. Unlike clients, supervisees are actively evaluated on their performance against criteria imposed on them from others.

III. Supervision vs. Consultation

A. Supervision

- In comparison with consultation, supervision is a longer-term relationship.
- Supervision is not a choice for those trainees inexperienced in the field.

B. Consultation

- Consultation, on the other hand, is usually not imposed on someone, and the consultant, unlike the supervisor, does not assume an evaluative role.
- Furthermore, the consultant may not be of the same professional discipline whereas in supervision the supervisor serves as a role model for the profession of which the supervisor and supervisee are members.

IV. Supervision Contracts

- A. To facilitate a working alliance between the supervisee and the supervisor, supervision agreements or contracts are suggested.
- B. According to Osborn and Davis (1996), supervision contracts should include the following:
 - 1. Purpose, Goals, and Objectives
 - 2. Context of Services (where, when, what modalities will be used, etc.)
 - 3. Methods of Evaluation
 - 4. Duties and Responsibilities of Supervisor and Supervisee (e.g., the behaviors expected from both supervisor and supervisee)
 - 5. Procedural Consideration (emergency procedures, record-keeping, etc.)
 - 6. Supervisor's Scope of Practice (the supervisor's experience and credentials should be made explicit)

METHODS OF SUPERVISION

The various methods used for supervision not only provide a means for training but also for evaluating the competence of the supervisee by providing various sources of information on the counselor's performance. Each method provides a specific, evaluative lens through which to view one aspect of the supervisee's work. The use of multiple methods will give the most accurate picture (Bradley and Ladany, 2001).

I. Methods and Modalities of Supervision

A. A number of methods or modalities of supervision have been utilized including:

- the use of one-way mirrors
- a bug in the ear
- audio taping
- video taping
- other methods

B. Supervision can occur as:

- live
- individual
- group
- team supervision (with many variations on these)

II. Group Supervision

- A. Group supervision consists of a number of trainees meeting together with a supervisor and is widely used in most training programs.
- B. The best size for a supervision group has not been agreed upon with suggestions ranging from 5 to 12 participants (cf., Aronson, 1990; Schreiber & Frank, 1983).
- C. The American Association for Marriage and Family Therapy (AAMFT) requires no more than six supervisees for group supervision.

III. Skills for Group Supervisors

- A. Supervision in a group requires knowledge and skills in group dynamics and in individual and group development (Bradley and Ladany, 2001).
- B. The supervisor should utilize the group context rather than simply attempt to do individual case supervision with each group participant.
- C. The group can provide a challenging and supportive environment for trainees.
- D. Shulman (1982) suggests that individual supervision should focus on the client while group supervision should focus on supervisee growth.

IV. Stages of Development in Group Supervision

Groups generally follow these stages of development:

- A. **Forming:** characterized by members getting to know each other; safety and security are important
- B. **Storming:** a stage of conflict and emotional expression; concern about issues of leadership and authority
- C. **Norming:** a stage of group cohesion in which the group establishes rules and norms
- D. **Performing:** characterized by a clear understanding of the work of the group and members roles
- E. **Adjourning (Mourning):** characterized by termination of the group and transition to life after the group (Bradley & Ladany, 2001; Bernard & Goodyear, 1998)

A group supervisor should be aware of group development and how it impacts the tasks of supervision. For example, a greater degree of structure and direction is needed in the **forming stage**. Likewise, in the **norming stage**, the supervisor needs to be aware of emerging norms of the group and shape them by modeling and by helping members to become aware of them (Bernard and Goodyear, 1998).

ETHICAL, PROFESSIONAL, AND LEGAL ISSUES

The Association for Counselor Education and Supervision (ACES) has endorsed Standards for Counseling Supervisors and Ethical Guidelines for Counseling Supervisors. The following are ethical issues relevant to supervision.

I. Dual Relationships

- A. Intimate relationships, therapeutic relationships, and social relationships are the common types of dual relationships between supervisor and supervisee (Bernard & Goodyear, 1998).
- B. Some have argued that dual relationships are inevitable between supervisee and supervisor because they both often share other experiences together (Goodyear & Sinnett, 1984).
 - For example, faculty and students in a graduate program often have informal contacts with each other.
 - In addition, a faculty supervisor may also be a student's professor or may sit on the student's dissertation committee (Bernard & Goodyear, 1998).
- C. It is always **inappropriate** for supervisors to do counseling with supervisees.
- D. Overall, dual relationships should be avoided if it is likely that the supervisor's judgment would be impaired or if the supervisee could be exploited.

II. Competence

- A. Supervisors are expected to be experienced and effective counselors; they also must be competent as supervisors above and beyond their competence as counselors (ACES Ethical Guidelines for Counseling Supervisors, 1993).
- B. Most state boards require specific credentials in supervision such as a certain number of hours of training (supervision of supervision) and experience as well as coursework in supervision.
- C. A counselor seeking supervision should verify that the supervisor is indeed approved by the state board for the license desired by the counselor.

III. Confidentiality and Informed Consent

- A. Confidentiality must be emphasized throughout supervision both in terms of the supervisee maintaining client confidentiality as well as the supervisor maintaining supervisee's confidentiality (Bernard & Goodyear, 1998).
- B. In addition, supervisees need to describe to clients the limits of confidentiality and to inform clients that they are receiving supervision (Bradley & Ladany, 2001).
- C. Trainees should enter supervision as well-informed as clients.
- D. Trainees should know:
 - 1. their responsibilities
 - 2. the supervisor's responsibilities
 - 3. the conditions for success
 - 4. the methods of evaluation (Bernard & Goodyear, 1998)

IV. Cultural Issues

- A. Important factors in the ethical and professional practice of supervision include:
 - 1. promoting cultural awareness
 - 2. identifying cultural influences on client behavior
 - 3. counselor-client interaction
 - 4. the supervisory relationship
 - 5. providing culturally-sensitive support (Fong & Lease, 1997)
- B. Supervisors need to be aware of the influence of unintentional racism, power dynamics, trust and vulnerability, and communication issues related to cultural differences (Fong & Lease, 1997).
- C. This is true in both the counselor-client relationship and in the supervisor-supervisee relationship.
- D. The cultural worldview, experience, and identity of the supervisee must be explored in the supervisory relationship in an open and honest fashion (Bernard & Goodyear, 1998).

V. Liability and Malpractice

A supervisor must accept two types of liability for supervisees (Bradley & Ladany, 2001):

- A. **Direct liability** refers to an action or inaction by the supervisor that causes harm to a client, such as failing to address the suicidal ideation of a supervisee's client.
- B. **Vicarious liability** occurs when the supervisor is held liable for the behavior of the supervisee even though the supervisor may be unaware of the behavior.
 - Malpractice means negligence in the performance of professional duties (Bradley & Ladany, 2001).
 - A supervisor may be guilty of malpractice (or at least contributory negligence) if he/she failed to give proper supervision.
 - If it can be demonstrated that a “demonstrable standard of care” has been neglected and that harm was directly caused, a supervisor can be held liable by either or both the client and the supervisee (Bradley & Ladany, 2001).

VI. Record-Keeping

- A. Proper record-keeping becomes increasingly important in a litigious era.
- B. The supervisor needs to be sure that **client records** are complete.
- C. **Supervision records** should also be consistently maintained. Bernard and Goodyear (1998) indicate supervisors need to pay more attention to this aspect of their contractual obligation with the supervisee.
- D. The following is a suggested outline for supervision records (Munson, 1993):
 - 1. The supervisory contract
 - 2. A statement of the supervisee's experience, training, and learning needs
 - 3. A summary of all performance evaluations
 - 4. Notation of all supervisory sessions
 - 5. Cancelled or missed sessions
 - 6. Notation of cases discussed and decisions made
 - 7. Significant problems encountered in supervision and how they were resolved

Chapter 12

Lifestyle & Career Development

LIFESTYLE AND CAREER DEVELOPMENT

NCE – Chapter 12

Chapter Outline

CAREER AND VOCATIONAL THEORIES

- I. Trait and Factor Career and Vocational Theory
 - A. Frank Parsons
 - B. Williamson
 - C. Herr and Cramer
 - D. Chartrand

- II. Personality Career and Vocational Theory
 - A. Holland
 - B. Roe
 - C. Bordin, Nachman, and Segal
 - D. Bordin

- III. Social Learning Career and Vocational Theory
 - A. Krumboltz, Mitchell, and Jones
 - B. Krumboltz
 - C. Dawis and Lofquist – Work Adjustment Theory
 - D. Accident/Chance Theory
 - E. Azin and Besalel’s “Job Club”
 - F. Schein’s Stages and Transitions
 - G. Status Attainment Theory
 - H. Human Capital Theory
 - I. Other Factors Influencing Career Choice

- IV. Developmental/Life Span Career and Vocational Theory
 - A. Ginzberg, Ginsburg, Axelrad, and Herma
 - B. Super
 - C. Havighurst
 - D. Schlossberg
 - E. Hoppock
 - F. Okun

- V. Decision Making Career and Vocational Theory
 - A. Teideman
 - B. Katz
 - C. Gelatt
 - D. Expectancy Theory
 - E. A Self-Efficacy Model
 - F. Bergland's 6 Steps of Decision Making
 - G. Pete and Harren
 - H. Casve Cycle
 - I. Eight Stage Approach
 - J. Crites
 - K. Conflict Model
 - L. Risk-Taking and Its Influence
- VI. Additional Career and Vocational Theories
 - A. Cognitive Information Processing Approach to Career Problem Solving
 - B. Career Development From a Social Cognitive Perspective
 - C. A Values-Based Holistic Model of Career and Life-Role Choices and Satisfaction
 - D. A Contextual Explanation of Career

SOURCES OF INFORMATION

- I. Information in Print
 - A. The Dictionary of Occupational Titles (DOT)
 - B. The Occupational Outlook Handbook (OOH)
 - C. The Guide for Occupational Exploration
 - D. Enhanced Guide for Occupational Exploration
 - E. Standard Occupational Classification Manual
- II. Computer Software
- III. Computer-Assisted Career Guidance (CACG)
- IV. Information on the Internet
 - A. Internet Tools
 - B. Specific Examples

CAREER AND VOCATIONAL COUNSELING FOR SPECIAL POPULATIONS

- I. Women in the Workplace
 - A. Needs-Based Socio-Psychological Model
 - B. Developmental Model of Occupational Aspirations
 - C. Factors Affecting Women
- II. Careers for Persons with Disabilities
 - A. Knowledge
 - B. Skills
- III. Counseling the Older Worker
- IV. Career Counseling of the Culturally Different

PLANNING CAREER DEVELOPMENT PROGRAMS

CAREER EDUCATION

GENERAL JOB MARKET INFORMATION

AMERICAN WORK ETHIC

ETHICAL GUIDELINES FOR CAREER COUNSELORS

- I. National Career Development Association (NCDA) Guidelines
- II. Competencies
- III. Record Keeping
- IV. Electronic Storage

LAWS GOVERNING DISCRIMINATION

- I. The Equal Pay Act
- II. Title VII of the Civil Rights Act of 1964
- III. The Nineteenth Century Civil Rights Act
- IV. The Age Discrimination in Employment Act (ADEA)
- V. The Rehabilitation Act
- VI. The American with Disabilities Act (ADA)
- VII. The Equal Opportunity Employment Commission (EEOC)
- VIII. Rehabilitation (Physical) Requirement Guidelines

RESUME WRITING AND COVER LETTERS

- I. Resume Writing
 - A. What Research Indicates
 - B. The Purpose of a Resume
- II. Cover Letter
 - A. Two Basic Types of Cover Letters
 - B. Purpose of a Cover Letter
 - C. Initiate Contact
 - D. General Characteristics and Recommendations

STRESS

- I. Type A Behavior
- II. Type B Behavior
- III. “Types” of Problem Employees

HISTORY OF THE AMERICAN COUNSELING ASSOCIATION

ADDITIONAL CAREER DEVELOPMENT TERMS

LIFESTYLE AND CAREER DEVELOPMENT

NCE – Chapter 12

CAREER AND VOCATIONAL THEORIES

I. Trait and Factor Career and Vocational Theory

Trait and Factor approaches focus on diagnosis. Individual strengths and weaknesses are evaluated to predict job satisfaction and success.

A. Frank Parsons

Trait and Factor Theory (A Matching Theory)

1. Trait and Factor theory is a three-part model developed by Frank Parsons and was first published in his book *Choosing a Vocation* (1909). Parsons is generally recognized as the "father of guidance."
2. His three-part model asserts that:
 - individuals must initially acquire a complete understanding of their own personal **traits**; that is, their particular characteristics and attributes including their strengths and weaknesses
 - individuals must ascertain the **factors** involved in a particular occupation; that is, what is needed attribute-wise for success
 - individuals must use "**true reasoning**" in examining these traits and factors in order to make correct choices and good decisions
3. Trait and Factor Theory is sometimes referred to as a "matching theory" due to the desired results being a match of traits and factors.

B. Williamson

1. Williamson (1950) wrote the highly influential book *How to Counsel Students*, in many ways an extension of Parson's work.
2. His approach to counseling became known as Directive Counseling because of its straightforward approach.
3. He lists six steps that trait and factor counselors follow:
 - Analysis
 - Synthesis
 - Diagnosis
 - Prognosis
 - Counseling
 - Follow-up

C. Herr and Cramer

Herr and Cramer (1996) put forth 16 different predictors of success used in trait and factor approaches. Out of these, they listed **8 primary predictors** on which information must be gathered:

- aptitudes
- needs
- interests
- values
- stereotypes and expectations
- adjustment
- risk taking
- aspirations

D. Chartrand

1. Chartrand (1991) indicated that contemporary models of trait and factor approaches have evolved into "person times environment" approaches (P x E) which postulates that:
 - Affective processes cannot be ignored
 - People and work environments differ in reliable, meaningful, and consistent ways
 - The greater the congruence between personal characteristics and job requirements, the greater the likelihood of success
2. This approach regards the P x E (Person x Environment) fit to be a dynamic "reciprocal process" with individuals shaping the environment and the environment shaping the individuals.

Contemporary Trait and Factor theorists are expanding the use of test data to look for congruence between individual personalities and work environments. This information can be most effectively used in conjunction with other data (Herr & Cramer, 1996).

II. Personality Career and Vocational Theory

A. Holland

1. Holland's theory is sometimes described as structural-interactive because it links various personality characteristics and corresponding jobs. It assumes that the individual is a product of heredity and environment:
 - a. The choice of an occupation is an expression of personality
 - b. Members of an occupational group have similar personalities and histories of personal development
 - c. Members of an occupational group will respond to many situations and problems in similar ways
 - d. Occupational achievement, stability, and satisfaction depend on congruence between personality and job environment
2. Holland's focus (1973) is considered by some to be a variation on trait and factor theory as he examined career choice through personality types. He offered four suppositions:
 - a. There are six personality types into which all people fall – **Realistic**, **Investigative**, **Artistic**, **Social**, **Enterprising**, and **Conventional** (RIASEC)
 - b. Six types of environments (occupational themes) parallel the personality types
 - c. Individuals search out environments that correspond to their personality type
 - d. Behavior is governed by the mutual influence of personality and environment
3. The preferences indicated by the **six personality types** and their relationships to pertinent occupation examples are as follows:
 - **Realistic (R)** – activities that involve explicit, ordered, or systematic manipulation of objects, tools, machines, or animals, such as a surveyor or mechanic.
 - **Investigative (I)** – observing, creative investigation, systematic, and symbolic concepts, such as a chemist or physicist.
 - **Artistic (A)** – ambiguous, free, unsystematized activities that include manipulation of physical, verbal, or human materials to create art forms or products, such as a graphic artist or writer.
 - **Social (S)** – manipulation of others to inform, train, develop, cure, or enlighten, such as teacher or counselor.
 - **Enterprising (E)** – manipulation of others to attain organizational goals or economic gain, such as political scientist, salesman, or executive.
 - **Conventional (C)** – explicit, ordered, systematic manipulation of data, such as an accountant or clerk.

4. In a 1985 refinement of his theory, Holland identified **4 secondary assumptions**:
 - a. **Consistency** – some types of persons or environments have more relationship to each other than do others
 - b. **Differentiation**
 - personal identity is defined as the possession of a clear and stable picture of one's goals, interests, and talents
 - environmental identity is preset when an environment has clear, integrated goals, tasks, and rewards that are stable
 - c. **Congruence** – different personality types require different environments
 - d. **Calculus** – the relationships within and between types or environments can be ordered according to a hexagonal model in which the distances between the types or environments are inversely proportional to the theoretical relationship between them
5. Holland's theory (1973) has had a great impact on the career counseling field despite criticism of its being too simplistic. He has developed three instruments in use by career counselors:
 - Vocational Preference Inventory (VPI)(1953)
 - Self-Directed Search (SDS)(1977)
 - Vocational Exploration and Insight Kit (VEIK)(1980)

B. Roe

1. Roe's (1976) theory was based on two major personality theories:
 - a. The work of Gardner Murphy (1947) theorized relatively predictable development of psychic energy and emphasis on the relationship between early childhood experiences and later vocational choices.
 - b. Maslow's concept of needs
Maslow arranged human needs in a hierarchy in which satisfaction of higher-order needs was dependent on satisfaction of lower-order needs. The needs, in ascending order, are:

(1) physiological needs	(6) respect and independence
(2) safety needs	(7) information
(3) belonging and love	(8) understanding
(4) importance	(9) beauty
(5) self-esteem	(10) self-actualization (maximizing of the utilization of the individual's abilities)
2. Roe saw vocational choice as heavily affected by the **child-rearing practices** used while the individual was developing. She noted three different practices:
 - a. **Emotional concentration on the child** – overprotecting and at the same time over-demanding behavior which makes the child dependent on parental approval for need gratification.
 - b. **Avoidance of the child** – emotional rejection of the child as well as physical neglect, prompting the child to look to non-persons and objects for gratification of needs.
 - c. **Acceptance of the child** – incorporating of the child into the family unit as an equal and encouraging independence and interest in occupations that balance personal and non-personal interests.
3. Roe was the first to categorize jobs into eight fields and six levels within each of those fields. The **eight fields** are:

(1) service	(5) outdoor
(2) business contact	(6) science
(3) organizations	(7) general culture
(4) technology	(8) arts and entertainment
4. Roe's **six levels** are:

(1) professional and managerial (independent responsibility)	(4) skilled
(2) professional and managerial (less independence or fewer responsibilities)	(5) semiskilled
(3) semiprofessional and small business	(6) unskilled

C. Bordin, Nachman, and Segal

Bordin, Nachman, and Segal (1963) formulated a comprehensive application of classic psychoanalytic concepts to career development.

1. Their work built upon Brill's (1948) concepts of guilt and exhibitionism and of the pleasure and the reality principles to explain the choice attraction of various vocations.
2. They maintain that connections exist between the early development of coping mechanisms and the later development of more complex behaviors.
3. Adult occupations are sought for their instinctual gratification; the need for instinctual gratification is developed in the first six years of life.

D. Bordin

Bordin (1984, 1990) later reformulated Bordin, Nachman, and Segal's theory to give more prominence to ego development. He defined seven propositions that emanate from one basic tenet. That basic tenet is that the participation of personality in work and career is rooted in the role of play in human life. Bordin's seven propositions are:

1. A sense of wholeness, the experience of job, is sought by all persons, preferably in all aspects of life.
2. The degree of fusion of work and play is a function of an individual's developmental history regarding compulsion and effort.
3. A person's life can be seen as a string of career decisions reflecting the individual's groping for an ideal fit between self and work.
4. The most useful system of mapping occupations for intrinsic motives will be one that captures lifestyles or character styles and stimulates or is receptive to developmental conceptions.
5. The roots of the personal aspects of career development are to be found throughout the early development of the individual, sometimes in the earliest years.
6. Each individual seeks to build a personal identity that incorporates aspects of father and mother, yet retains elements unique to oneself.
7. One source of perplexity and paralysis at career decision points will be found in doubts and dissatisfactions with current resolutions of self.

III. Social Learning Career and Vocational Theory

Social Learning theory is an outgrowth of the general social learning theory of behavior proposed by Albert Bandura.

Its roots are in reinforcement theory and classical behaviorism.

This theory suggests:

1. An individual can control little or none of his/her genetic background and environment.
2. Genetic background and environment necessarily affect the learning experiences that an individual encounters.
3. It assumes, however, that the individual's personality and behavioral patterns arise primarily from his unique learning experiences rather than from innate developmental or psychic processes.
4. It recognizes that humans are intelligent, problem-solving individuals who:
 - a. strive at all times to understand the environment that surrounds them
 - b. in turn control their environments to suit their own purposes and needs
5. It is not a deterministic theory but rather says individuals always possess alternatives.

A. Krumboltz, Mitchell, and Gelatt

1. Krumboltz, Mitchell, and Gelatt (1975) identified **four factors that influence career decisions**:
 - a. **Genetic endowment and special abilities** such as:
 - race
 - sex
 - physical appearance and characteristics
 - intelligence
 - musical ability
 - artistic ability
 - muscular coordination
 - b. **Environmental conditions and events** such as:
 - number and nature of job and training opportunities
 - social policies and procedures for selecting trainees and workers
 - neighborhood and community influences
 - rate of return for various occupations
 - technological developments
 - labor laws and union rules
 - changes in social organizations
 - physical events
 - c. **Learning experiences** such as:
 - Instrumental Learning Experiences (ILEs) in which antecedents, covert, and overt behavioral responses and consequences are present
 - Associative Learning Experiences (ALEs) in which the learner pairs a previously neutral situation with some emotionally positive or negative reaction
 - d. **Task approach skills** such as:
 - problem-solving skills
 - work habits
 - mental set
 - emotional responses
 - cognitive processes that both influence outcomes and are outcomes themselves
2. These four types of influences and their interactions lead to **three types of outcomes**:
 - a. **Self-Observation Generalizations (SOGs)** are overt or covert statements evaluating one's own actual or vicarious performance in relation to learned standards
 - b. **Task Approach Skills (TASs)** are cognitive and performance abilities and emotional predispositions for interpreting, coping with, and predicting the environment
 - c. **Actions or Entry Behaviors** are overt steps in career progressions (applying for a job, changing a college major)

B. Krumboltz

1. Krumboltz (1983) identified several types of problems that can arise from faulty self-observation, generalizations, or inaccurate interpretation of environmental conditions:
 - Persons may fail to recognize that a remediable problem exists.
 - Persons may fail to exert the effort needed to make a decision or to solve a problem.
 - They may eliminate a potentially satisfying alternative for inappropriate reasons.
 - Persons may choose poor alternatives for inappropriate reasons.
 - Persons may suffer anguish and anxiety over perceived inability to achieve goals.
2. Krumboltz (Mitchell & Krumboltz, 1984) believes it is the counselor's responsibility to confront the client's above listed problems. He offers various methods for identifying and acting on private beliefs and identified stressors:
 - assessment of the content of the client's self-observation, world view generalizations, and the processes by which they arose
 - structured interviews
 - thought listing
 - in vivo self-monitoring
 - imagery
 - career decision-making simulations
 - reconstruction of prior events
 - behavioral inferences and feedback
 - use of psychometric instruments
 - use of cognitive restructuring techniques to help alter dysfunctional or inaccurate beliefs and generalizations
 - use of simple positive reinforcement
 - providing appropriate role models
 - the use of video and the inclusion of problem-solving tasks for viewers
 - use of computerized guidance systems to provide and to reinforce problem-solving tasks
 - teaching belief-testing processes
 - analyzing task-approach skills and teaching such skills to those who lack them

C. **Work Adjustment Theory – Dawis and Lofquist**

Dawis and Lofquist (Dawis 1994) theorize that job satisfaction and work adjustment result from correspondence between individual and environment:

- Each individual seeks to achieve and maintain correspondence with his or her environment.
- Work represents a major environment to which most individuals must relate.
- In the case of work, correspondence can be described in terms of mutual fulfilling of the individual's and work environment's requirements.
- Work adjustment is a continuous and dynamic process by which one seeks to achieve and to maintain correspondence with one's work environment.
- The stability of the correspondence between the individual and the work environment is manifested as tenure in the job.
- **Satisfactoriness** and **Satisfaction** indicate the correspondence between the individual and the work environment.
 - **Satisfactoriness** is an external indicator derived from sources other than the worker's own self-appraisal.
 - **Satisfaction** is the worker's appraisal of the extent to which the work environment fulfills his requirements.
- The levels of satisfactoriness and satisfaction observed for a group of individuals with substantial tenure in a specific work environment establish the limits of those qualities from which tenure can be predicted for other individuals.
- The work personalities of individuals who fall within the limits of satisfactoriness and satisfaction for which substantial tenure can be predicted may be inferred to be correspondent with the specific work environment.

D. Accident/Chance Theory

1. Bandura

Bandura (1982) proposed that chance encounters play a prominent role in shaping the course of human lives. These encounters can be described as an unexpected meeting of persons with symbolic contacts, such as attending a certain lecture, reading a specific book, or unexpectedly witnessing a particular event on television or in person. Each of these may have such an effect on an individual that it stimulates the pursuit of a new life path.

Bandura delineated two determinants influencing chance encounters:

a. Personal Determinants such as:

- entry skills
- emotional ties
- values
- personal standards

b. Social Determinants such as:

- milieu rewards (the types of rewards and sanctions if a chance encounter alters a life)
- symbolic environment and information
- milieu reach and closedness (cults, etc.)
- psychological closeness to outside influences

2. Cabral and Salamone

a. Cabral and Salamone (1990) contend that there are two conclusions to be drawn regarding chance events:

- (1) Chance operates on a continuum of events or encounters that are totally unforeseen.
- (2) Persons react differently to unforeseen encounters or events.

b. Cabral and Salamone suggest the following effects of chance on career decisions:

- Chance is inevitable and plays an important role in shaping career decisions.
- Career decisions are rarely purely rational but are some combination of planning and happenstance.
- The critical dimensions of chance encounters or events are their timing in relation to the individual's development and the contexts within which they occur.
- It is possible to affect the potential for certain types of chance events by entering or avoiding different contexts.
- Individuals are most vulnerable to the effects of chance during life transitions, particularly those that occur early in the career and those that have not been anticipated.

E. Azin and Besalel's "Job Club"

1. Azin and Besalel (1980) (Gonzalez & Peterson, 2000) have developed a practical concept of the "job club." This approach is based on the behavioral principle of positive reinforcement.
2. Focusing on professionals who had lost jobs, Azin developed a structured approach so that members of the job club could reinforce each other's progress in job seeking.
3. It is a proactive, action-oriented approach in contrast with theories which emphasize the understanding of what happens in a crisis.

F. Schein's Stages and Transitions

Schein (1971) has described an organizational career as a series of stages and transitions. He recognized the importance of organizational structures and expectations along with the individual's career cycles in career development. Schein's stages and the activities typical of each stage are:

1. **Preentry Stage** – preparation, education, anticipatory socialization
2. **Entry Stage** – recruitment, rushing, testing, screening, selection, acceptance, induction, and orientation
3. **First Regular Assignment Stage** – first testing by the person of his own capacity to function, granting of real responsibility, passage through functional boundary with assignment to specific job or department

Substages:

- Learning the job
 - Maximum performance
 - Becoming obsolete
 - Learning new skills
 - Promotions or leveling off – indoctrination and testing of the person by the immediate work group leading to acceptance or to rejection, further education and socialization, preparation for higher status through coaching, seeking visibility, finding sponsors
4. **Second Assignment Stage** (repeat process under number 3.)
 5. **Granting of Tenure Stage** – passage through another inclusion boundary or termination and exit, preparation for exit, rites of exit
 6. **Postexit Stage** – granting of peripheral status

G. Status Attainment Theory (Lenz, Peterson, Reardon, & Sampson, 2000)

1. Status Attainment Theory as explained by Hotchkiss and Borow (1990) predicts the prestige level of a person's job from an individual's social (particularly family) background.
2. The family status (particularly the father's occupational and socioeconomic status, income, and education) and cognitive variables (educational performance) affect social-psychological processes which act to predict educational attainment (years of schooling).
3. Educational attainment is then used to predict occupational attainment measured by the status or prestige levels of the career.
4. Criticism of the Status Attainment Theory
 - a. Although Status Attainment Theory has been useful in predicting occupational attainment, Sonnenfeld (1989) has criticized it for:
 - being unable to adequately explain later status changes once an individual has begun employment
 - not paying enough attention to changing social values that have led to less agreement on the definition of a successful career
 - b. Sonnenfeld claims that status within a firm should be measured rather than occupational attainment.

H. Human Capital Theory (Lenz, Peterson, Reardon, & Sampson, 2000)

1. Human Capital Theory is the primary economic theory related to career development. It suggests that individuals invest in their own education, training, moving costs, etc. in order to achieve a higher-paying job with more prestige (Becker, 1964, Wachter, 1974).
2. In some ways, Human Capital Theory can be seen as an endorsement of trait and factor theory. It emphasizes the role of the assessment of interests and abilities in selecting an occupation.
3. Human Capital Theory differs from trait and factor theory in that it emphasizes career choice as a long-term process/investment and focuses on income.
4. Criticisms of Human Capital Theory
 - Human Capital Theory (Lenz, Peterson, Reardon, & Sampson, 2000) has been criticized as being simplistic because its goal is a monetary reward.
 - It ignores other goals, such as being elected to political office, helping others, or leisure time.
 - It also assumes that the labor market is open equally to all workers.
 - Duncan, Prus, and Sandy (1993) have shown that although Human Capital Theory may explain a woman's decision to work, it does not explain her occupational choice.
 - It also does not consider job discrimination against women and people from different cultural backgrounds in predicting individual earnings.

I. Other Factors Influencing Career Choice

1. Cultural and Class Boundaries

Chance and/or intervening variables are not the only factors influencing career choice or development. The breadth of an individual's culture or social class boundaries has much to do with the choices that can be considered, selected, and implemented.

2. Social Factors

Lipsett (1962) proposed that counselors must understand the implications of the following social factors as they interact with career development:

- a. **Social Class Membership** – such as occupation and income of parents, education of parents, place and type of residence, ethnic background
- b. **Home Influences** – such as parental goals for the individual, influence of siblings, and family values
- c. **School Influences** – such as scholastic achievement, relationships with peers and faculty, values of the school
- d. **Community Influences** – such as group goals and values, special opportunities or influences
- e. **Pressure Groups** – describes the degree to which an individual or his/her family has come under any particular influence
- f. **Role Perception** – describes the individual's perception of self as a leader, follower, isolate, as well as the degree to which the individual's perception is in accord with the way others see him

3. Role Models and Values

In a pluralistic culture such as the United States, persons of different ethnic or racial backgrounds are likely to differ in the types of role models available to them. Perhaps more important, different cultures allocate values differently, and these values have consequences for behavior.

IV. Developmental/Life Span Career and Vocational Theory

Developmental/life span theorists are differentiated by the developmental stages and population groups examined by the theorists.

A. Ginzberg, Ginsburg, Axelrad, and Herma

1. Ginzberg, Ginsburg, Axelrad, and Herma (1951) investigated upper middle-class, white, Protestant, and Catholic populations, identifying three major periods in the career choice process:
 - Fantasy (0 - 11 years)
 - Tentative (11 - 18 years)
 - Realistic (18 - into the 20s)
2. From this study, they theorized three basic components:
 - Occupational choice evolves; it's a process
 - This process is mainly unalterable
 - Every choice employs compromise

B. Super

1. Super

Super (1969) characterized his theory as a loosely unified group of theories dealing with distinct phases of career development taken from developmental, differential, phenomenological, and social psychology and held together by self-concept or personal construct theory. His model presents a longitudinal, developmental approach rather than a one-time choice, also referred to as **career maturity (Crites)**.

2. Lifespan

Super (1984) gives prominence to individuals' mastery of increasingly complex tasks at different stages of career development. He has formulated life stages and the tasks that comprise them as follows:

a. **Growth** Life Stage Tasks (birth to 14 years)

Develop a picture of the kind of person one is and of the world of work and an understanding of the meaning of work

Three Substages:

- **Fantasy** (4 - 10 years) – Needs are dominant; role-playing in fantasy is important.
- **Interest** (11 - 12 years) – Likes are the major determinant of aspirations and activities.
- **Capacity** (13 - 14 years) – Abilities are given more weight and job requirements are considered.

b. **Exploration** Life Stage Tasks (14 – 24 years)

Implementing a vocational preference, developing a realistic self-concept, and learning more about various opportunities

Three Substages:

- **Tentative** (14 - 15 years) – Needs, interests, capacities, values, and opportunities are all considered; tentative choices are made and tried out in fantasy, discussion, courses, work, etc.

Task: Crystallizing a vocational preference

- **Transition** (18 - 21 years) – Reality considerations are given more weight as the person enters the labor market or professional training and attempts to implement a self-concept.

Task: Specifying a vocational preference

- **Trial (with) Little Commitment** (22 - 24 years)

A seemingly appropriate occupation having been found, a first job is located and is tried out as a potential for life work. Commitment is still provisional, and if the job is not appropriate, the person may reinstitute the process of crystallizing, specifying, and implementing a preference.

c. **Establishment** Life Stage Tasks (24 – 44 years)

Finding opportunity to do desired work, learning to relate to others, consolidation and advancement, making occupational position secure, and settling down into a permanent position

Two Substages:

- **Trial-Commitment and Stabilization** (25 - 30 years) – Settling down. Securing a permanent place in the chosen occupation may prove unsatisfactory, resulting in one or two changes before the life work is found or before it becomes clear that the life work will be a succession of unrelated jobs.
- **Advancement** (31 - 44 years) – Effort is put forth to stabilize, to make a secure place in the world of work. For most persons, these are the creative years. Seniority is acquired; clientele are developed; superior performance is demonstrated; qualifications are improved.

d. **Maintenance** Life Stage Tasks (44 – 64 years)

Having made a place in the world of work, the concern is how to hold on to it. Little new ground is broken; continuation of established pattern. Concerned about maintaining present status while being forced by competition from younger workers in the advancement stage.

Tasks: Accepting one's limitations, identifying new problems to work on, developing new skills, focusing on essential activities, and preservation of achieved status and gains

e. **Decline** Life Stage Tasks (age 64 and up)

Developing non-occupational roles, finding a good retirement spot, doing things one has always wanted to do, and reducing working hours

Two Substages:

- **Deceleration** (65 - 70 years) – The pace of work slackens, duties are shifted, or the nature of the work is changed to suit declining capacities. Many men find part-time jobs to replace their full-time occupations.
- **Retirement** (71 years and up) – Variation on complete cessation of work or shift to part-time, volunteer, or leisure activities

3. Super's Life-Roles

Super (1980) depicts life span, life-role development through the **life-career rainbow**, which presents:

a. Six **life roles**:

- (1) Child
- (2) Student
- (3) Leisurite
- (4) Citizen
- (5) Worker
- (6) Homemaker

b. Five **life stages**:

- (1) Growth
- (2) Exploration
- (3) Establishment
- (4) Maintenance
- (5) Decline

4. Super's Career Maturity

Super and his colleagues (Thompson & Lindeman, 1981) have done extensive research with adolescents on **career maturity** (readiness of individuals to make good career choices). They identify the different components of career maturity in an inventory of career orientation made up of five subscales. The subscales are:

- **Career planning** – How much an individual thinks that he or she knows about these activities, not how much he or she actually knows.
- **Career exploration** – Differs from career planning in that career planning concerns thinking and planning about the future, and career exploration deals with use of resources; taken, together Super calls them career development attitudes.
- **Decision making** – The student must know how to make a decision.
- **World-of-work information** – Knowledge of developmental tasks and timing, and knowledge of job duties in a few selected occupations, as well as job application behaviors.
- **Knowledge of preferred occupational group** – Thorough knowledge about individual abilities and interests relative to the different occupational groups.

C. Havighurst

Havighurst's (1964) theory proposes a six-stage life-long process of career development. He was the first to postulate that one must successfully complete the tasks of one stage before moving on to the next.

D. Schlossberg

- Schlossberg's (1984) theory primarily focuses on adult career development with five propositions:
 1. Social expectations mandate adult behavior instead of the proverbial biological clock.
 2. Behavior will fluctuate from acting as a function of a life stage to sometimes acting as a function of age.
 3. Sex differences are more influential than either age or stage differences.
 4. Adulthood is a state of constant adaptation and reassessment of self due to the never-ending stream of transitions that are a necessary part of life.
 5. The recurrent themes of adulthood are identity, intimacy, and generativity.
- She defined the career transition process as changes that take place over time, for better or worse. She enumerated 4 distinct types of career transitions:
 1. Anticipated Career Transitions – events that will happen in the life span of most individuals, such as marriage.
 2. Unanticipated Career Transitions – events that are not expected such as being fired or transferred.
 3. "Chronic Hassles" – situations such as a long commute to work.
 4. Non-events (events that don't happen) – such as a promotion that doesn't happen.
- To cope with these changes, the individual is affected by “coping moderators” such as the transition itself, the environment, and the individual's personality.
- Since numerous adults experience career transitions, Schlossberg's work is particularly helpful in giving these adults an effective framework from which to make their vocational decisions.

E. Hoppock

1. Composite Theory

- In 1976, Robert Hoppock produced *Occupation Information*, a major work which is used today as a critical reference. Hoppock's research on job satisfaction has proven beneficial to career counseling.

2. Hoppock's Needs Theory

- Hoppock's emphasis is on individual needs (1976). His theory of career development holds that while occupations may not satisfy all of a client's needs, he or she still chooses an occupation to meet those needs. Hoppock identified several physical needs (similar to Maslow's hierarchy of needs) and psychological needs (such as the belief that a certain career will fulfill needs, and the need to be compensated properly) that lead to job choices. The better clients know what their needs are, the clearer and easier their career choice becomes.

F. Okun

Barbara Okun wrote *Working with Adults, Individual, and Career Development* (1984).

Okun's model is a synthesis or integration of developmental and systems theory. Her focus is on the circular or reciprocal relationships that exist among the three domains of individual development, family development, and career development. The interaction of these domains represents a constant struggle between the needs of systems for stability and the developmental movement towards adaptation and change.

Her Developmental Systems Theory has three life cycles: Individual

Family

Career

and three stages: Early

Middle

Late

V. Decision Making Career and Vocational Theory

The Decision Making theorists endeavored to explain how an individual makes a career/vocational decision.

A. Tiedeman

1. Tiedeman's (1963) model has seven steps, the first four of which describe steps in the period of **anticipation or preoccupation**:
 - a. exploration
 - b. crystallization
 - c. choice
 - d. clarification
2. The last three steps describe the steps in the period of **implementation or accommodation**:
 - a. induction
 - b. reformation
 - c. integration
3. Tiedeman's conclusion was that a decision-guided life is proactive rather than reactive.
4. Tiedeman and his associates used a cubistic model of decision-making (Miller & Tiedeman, 1972). Later Miller and Tiedeman modified the presentation of their concepts into a pyramid (Miller & Tiedeman, 1977).
5. This model includes four levels:
 - a. learning about
 - b. problem solving
 - c. solution-using
 - d. solution-reviewing
6. Each of these levels elaborated and coupled with a hierarchy of decision strategies.
7. Tiedeman and his colleagues have continued to clarify and to refine their theory focusing on "self-empowerment" and the utilization of "I" power to unite ego and value development. They seem dedicated to self-empowerment as the central proposition in creating a career.

B. Katz

Katz's (1973) model emphasized the importance of **identifying and clarifying values** before considering other options, additional information, or possible or probable outcomes. From his work came the computer-based program, the *System of Interactive Guidance and Information* (SIGI), particularly useful to those on the junior college level.

C. Gelatt

1. Gelatt's Early Model

Gelatt's (1962) model maintains that **information processing** is the basis for decision making. This approach advises that quality self-development is more likely to be achieved if the individual fully comprehends the possible chain of events that naturally follow certain decisions. His model has five steps in the completion of the decision-making process. The individual:

- a. recognizes a need to make a decision and then establishes an objective or a purpose
- b. collects data and looks at possible courses of action
- c. uses the data to determine possible courses of action, outcomes, and probability of outcomes
- d. focuses attention on his/her value system
- e. evaluates and makes a decision that can be a terminal decision or investigatory decision

2. Gelatt's Later Model

- a. Gelatt's (1991) later model of career decision-making is called "**positive uncertainty**." Uncertainty describes the condition of today's river of life. The successful decision-maker navigating the river needs to be understanding, accepting, and even positive about that uncertainty.

- b. He proposes a two-by-four process, two **attitudes** and four **factors**.

The **two attitudes** are:

1. Accept the past, present, and future as uncertain
2. Be positive about uncertainty

The **four factors** to be considered are:

1. What you want
2. What you know
3. What you believe
4. What you do

D. Expectancy Theory

1. Expectancy theory is expressed in mathematical terms:
EXPECTANCY times VALENCE = MOTIVATION
2. Vroom (1964) uses the term **valence** to refer to affective orientations as distinguished from actual satisfactions.
3. This theory indicates that valence is not sufficient to promote action, but it must be combined with expectancy of the preferred outcome in order for the individual to move towards it.

E. A Self-Efficacy Model

1. Hackett and Betz
Research indicates that there are differences in the development processes of men and women. Hackett and Betz (1981) suggest that women who believe they are incapable of performing certain tasks (low self-efficacy) limit their career mobility and restrict their career options.
2. Bandura
Bandura's (1989) Social Learning Theory emphasizes that self-efficacy involves an individual's thoughts and images both of which influence psychological functioning. As explained by Bandura:

Those who have a high sense of efficacy visualize success scenarios that provide positive guides for performance and they cognitively rehearse good solutions to potential problems. Those who judge themselves as inefficacious are more inclined to visualize failure scenarios and to dwell on how things will go wrong. Such inefficacious thinking weakens motivation and undermines performance (p. 729).

F. Bergland's 8 Steps of Decision Making

Bergland (1974) suggested that the basic strategy of decision-making is problem solving. He offers the following series of stages that the decision-maker should be helped to complete:

1. Defining the problem
2. Generating alternatives
3. Gathering information
4. Developing information-seeking skills
5. Providing useful sources of information
6. Processing information
7. Making plans and selecting goals
8. Implementing and evaluating plan

G. Pete and Harren

Pete and Harren (Herr & Cramer, 1996) have described decision-making problems in terms of four elements:

1. The set of **objectives** that the decision-maker seeks to achieve.
2. The set of **choices**, or alternative courses of action, among which the decision-maker must choose.
3. A set of possible **outcomes** that is associated with each choice.
4. The ways each outcome might be assessed with respect to how well it meets the decision-maker's objectives, the **attributes** of each outcome.

H. CASVE Cycle

Lenz, Peterson, Reardon, and Sampson (1991) propose the CASVE Cycle for decision-making:

- **C**ommunication - identifying a need
- **A**nalysis - interrelating problem components
- **S**ynthesis - creating likely alternatives
- **V**aluing - prioritizing alternatives
- **E**xecution - forming means-ends strategies

I. Eight Stage Approach

1. Yost and Corbishley (1987) proposed an eight stage approach to career choice counseling:
 - a. initial assessment
 - b. self-understanding
 - c. making sense of self-understanding data
 - d. generating alternatives
 - e. obtaining occupational information
 - f. making the choice
 - g. making plans
 - h. implementing plans
2. What sets this plan apart from typical sequence approaches applied to career choice counseling is its emphasis on the client's psychological complexity.

J. Crites

1. Crites (1969) has defined indecision as "the inability of the individual to select, or commit himself to a particular course of action which will eventuate in his preparing for and entering a specific occupation (p. 615)."
2. He cites three possible causes for **indecision**:
 - a. The multipotential individual who is unable to designate one goal from among many choices.
 - b. The undecided individual who cannot make a choice from among available alternatives.
 - c. The uninterested individual who is uncertain about a choice because of lack of an appropriate interest pattern.
3. He differentiates indecision from **indecisiveness**, which stems from personal problems rather than from doubts related to a specific career choice, perhaps because of the pain involved in decision making.

K. Conflict Model

Janis and Mann (1977) have suggested **four defective patterns** of decision-making:

1. Unconflicted adherence – The individual simply denies any serious risks from current course of action.
2. Unconflicted change to new course of action – The individual simply denies any serious risks in making a decision or change.
3. Defense avoidance – The individual avoids anything that might stimulate choice anxiety or painful feelings and gives up looking for a solution.
4. Hypervigilance – The individual becomes extremely emotionally excited as the time constraints of decision making are made more pressing.

L. Risk-Taking and Its Influence

- Another personality variable that is related to vocational choice is risk-taking. Early work (Ziller, 1957) found a significant relationship between risk acceptance and career choice. Later studies (Burnstein, 1963; Mahone, 1960; Morris, 1966) also indicated that risk acceptance plays a part in vocational decisions.
- However, a large-scale study by Slakter and Cramer (1969) has demonstrated that current measures of risk-taking are too crude to capitalize on this relationship.
- Herr and Cramer (1996) propose that the high risk-taker's openness to new experiences and that person's rejection of tradition may indicate self-confidence in dealing adequately with life contingencies.

VI. Additional Career and Vocational Theories

A. Cognitive Information Processing Approach to Career Problem Solving

The Cognitive Information Processing Approach to Career Problem Solving (CIP) by Peterson, Sampson, and Reardon (1991) is applied to career development in terms of how individuals make a career decision and use information in career problem solving and decision making. It is based on 10 assumptions:

1. Career choice results from an interaction of cognitive and affective processes.
2. Making career choices is a problem-solving activity.
3. The capabilities of career problem solvers depends on the availability of cognitive operations as well as knowledge.
4. Career problem solving is a high memory-load task.
5. Motivation is the desire to become a better career problem solver in order to make better choices through a better understanding of oneself and the occupational world.
6. Career development involves continual growth and change in knowledge structures.
7. Career identity depends on self-knowledge.
8. Career maturity depends on one's ability to solve career problems.
9. The ultimate goal of career counseling is achieved by facilitating the growth of information-processing skills.
10. The ultimate aim of career counseling is to enhance the client's capabilities as a career problem solver and a decision maker.

B. Career Development from a Social Cognitive Perspective

1. Lent, Brown, and Hackett (1996) offer a Social Cognitive Career Theory (SCCT) to compliment existing cognitive theories. Its major goals are:
 - To find methods of defining specific mediators from which learning experiences shape and subsequently influence career behavior.
 - To explain how variables such as interests, abilities and values interrelate.
 - To explain how all variables influence individual growth and how environmental influences lead to career outcomes (most important component).
2. Key to this theory is the personal determinants of career development:
 - self-efficacy
 - outcome expectations
 - personal goals
3. Emphasized in this theory is the term "personal agency," which reflects how and why individuals exert power either to achieve a solution or to adapt to career changes.
4. SCCT makes four basic assumptions:
 - a. Interests are strongly related to one's self-efficacy and outcome expectations.
 - b. Performance accomplishments in a specific endeavor will lead to interests in that endeavor to the extent that they foster a growing sense of self-efficacy.
 - c. Self-efficacy and outcome expectations affect career-related choices largely (though not completely) through their influence on interests.
 - d. Past performance affects future performance partly through people's task mastery abilities and partly through the self-efficacy perceptions they develop, which presumably help them to organize their skills and persist despite setbacks.
5. SCCT also subscribes to Bandura's (1986) model of causality, known as the **Triadic Reciprocal Interaction System**. All three variables interact to the point of affecting one another as causal influences of an individual's development. The three variables of the Triadic Reciprocal Interaction System are:
 - a. Personal and physical attributes
 - b. External environmental factors
 - c. Overt behavior

C. A Values-Based Holistic Model of Career and Life-Role Choices and Satisfaction

Brown's (1996) **values-based approach** assumes that human functioning is influenced and shaped by a person's value orientation, which is seen as a strong determinant in rationalizing behavior roles. This model has **six basic propositions**:

1. There are only a small number of values that individuals prioritize.
2. Highly prioritized values are the most important determinants of life-role choices if they meet the following criteria:
 - One option must be available to satisfy the life-role value.
 - Options to implement life-role values are clearly delineated.
 - The difficulty level of implementing each option is the same.
3. Values are acquired through learning from values-laden information in the environment. This information is cognitively processed and interacts with the individual's inherited characteristics. Other factors that influence social interactions and opportunities are cultural background, gender, and socioeconomic level. These factors subsequently influence choice of careers and other life roles.
4. Life satisfaction is dependent on life roles that satisfy all essential values.
5. A role's salience is directly related to the degree of satisfaction of essential values within roles.
6. Success in a life role is dependent on many factors, some of which are learned skills and some of which are cognitive, affective, and physical aptitudes.

D. A Contextual Explanation of Career

1. **Contextualism** is a proposed method of establishing a “contextual action” explanation of career research and career counseling.
2. The major focus of this theory is on **organizing the interpretation of human actions**, the ever-changing, ongoing interplay relationship between the person and the environment because they are considered inseparable.
3. This theory studies **action systems**, which are composed of joint and individual actions and two terms referred to as:
 - **project** – agreement of actions between two or more people
 - **career** – like project, except that it extends over a longer period of time and includes more actions.
4. Action systems are composed of physical and verbal behavior.
5. **Functional steps** refer to higher-level processes than action.
6. **Goals**, the highest level of action, usually represent the general intention of the individual or group.

SOURCES OF INFORMATION

I. Information In Print

A. The Dictionary of Occupational Titles (DOT)

The Dictionary of Occupational Titles (DOT), continuously updated and published by the U.S. Department of Labor, contains information about approximately 22,000 jobs in nine categories. All jobs are designated by a nine-digit number. **The first digit** refers to one of nine occupational categories. **The next two digits** indicate one of 82 occupational divisions. These are then subdivided into 549 three-digit occupational groups. **The middle three digits** of the nine-digit code number refer to worker traits. **The final three digits** indicate the alphabetical order of titles within the six-digit code groups. It is now on-line at: <http://www.dictionar-occupationaltitles.net/>.

B. The Occupational Outlook Handbook (OOH)

The Occupational Outlook Handbook (OOH), published by the U.S. Department of Labor, lists over 800 of the most popular careers along with resources that provide additional information. It forecasts the employment growth phases for these careers.

C. The Guide for Occupational Exploration

The Guide for Occupational Exploration published by the U.S. Department of Labor utilizes three-digit codes somewhat similar to the first three digits of the DOT code. The difference is that these codes are more related to the interest requirements of the occupations than are the DOT codes. The Guide for Occupational Exploration lists 12 basic interest areas and occupations in 348 subgroups with the DOT code given for each code or occupation in the subgroup.

D. Enhanced Guide for Occupational Exploration

The Enhanced Guide for Occupational Exploration uses a three-digit code, but codes are more related to the interest requirements of occupations.

E. Standard Occupational Classification Manual (SOC)

1. This more complex manual clusters jobs by similar work functions rather than by interests. There are four levels of classification:
 - a. division
 - b. major group
 - c. minor group
 - d. unit group

2. The Standard Occupational Classification Manual gives 22 broad occupational divisions. The SOC was developed to bridge the DOT and a classification system developed by the U.S. Census Bureau.
 - a. Fields (Boyles, 1998)
 - (1.) Dictionary of Holland Occupational Codes
 - (2.) Dictionary of Occupational Codes
 - (3.) Encyclopedia of Associations
 - (4.) National Trade and Professional Associations of the United States
 - (5.) Newsletters in Print
 - (6.) Standard and Poor's Industry Surveys
 - (7.) Standard Industrial Classification Manual
 - (8.) The Information Please Business Almanac & Desk Reference
 - (9.) U.S. Industrial Outlook
 - (10.) Many and varied publications for individual fields/industries

 - b. Companies (Boyles, 1998)
 - (11.) The Almanac of American Employers
 - (12.) Corporate Jobs Outlook!
 - (13.) Dun & Bradstreet's Million Dollar Directory – Top 50,000 Companies
 - (14.) Fortune Magazine's 500
 - (15.) Hoover's Handbook of American Business (and more)
 - (16.) Periodicals – Fortune, Business Week, Forbes, Wall St. Journal
 - (17.) Moody's Manuals
 - (18.) Standard and Poor's
 - (19.) Thomas Register
 - (20.) Ward's Business Directory

 - c. Individuals
 - (21.) Consultants and Consulting Organizations Directory

 - d. Contacts Influential: Commerce and Industry Directory
 - (22.) Standard and Poor's Register of Corporations, Directors and Executives

COMPUTER-ASSISTED CAREER GUIDANCE (CACG)

II. Computer Software

The most popular computer software programs dealing with career choices are:

- DISCOVER II
- CHOICES
- SIGI PLUS
- CVIS
- GIS
- ISVD
- ECES

III. Computer-Assisted Career Guidance (CACG)

A. CACG systems are rapidly becoming a core element in the delivery of career and educational guidance service in the U.S. Trends in CACG system development include:

1. Increased diversity of systems.
2. Increased availability of information within the systems.
3. Greater potential for integrating CACG systems with existing career guidance services and programs in different types of organizational settings.
4. International and non-English-language versions of the systems.

B. CACG systems have been used (Herr and Cramer, 1996) in career guidance in four ways:

1. Computers serve as data processing tools by storing counselee data and subsequently retrieving them in various ways.
2. Computers are used as substitutes for some counselor functions that go beyond simple information processing.
3. The computer is viewed as a substitute counselor, at least for functions that involve systematic, consistent, and selective use of a limited number of simple skills.
4. The computer is used for phone-linked job placement systems in various settings, whereby individuals can transmit resumes, make appointments, locate jobs, and so on. At home, users can plug in, log on, and find a job.

IV. Information on the Internet

The internet offers an extensive body of knowledge. Many of the print media have also set up web sites and update them regularly. Many of the sites also list links to other sites that are providing the same type of information, providing leads to more data. However the internet does have disadvantages:

- One problem is organizing the information in a usable form; although there is a large variety of information, it is often not laid out in an easily organized format.
- A second problem is that authors of the various sites cannot be regulated, so some sites are of dubious utility.

A. Internet Tools

Internet tools and their possible uses are available as follows (Cabaniss, K., 2002):

1. Electronic Email – counseling; marketing; screening; client/counselor correspondences for scheduling, inter-session monitoring and post-therapeutic follow-up; client record transfer; referrals; intake; homework; research; and professional collegiality
2. Websites/homepages – marketing/advertising; information dissemination; and publications
3. Videoconferencing – counseling; homework; referrals; and consultation
4. Bulletin board systems/listservs/newsgroups – consultation; referrals; resources for information; and professional collegiality
5. Computerized simulation – supervision and skills training
6. Databases/FTP sites – research; information resources for counselors; self-help libraries; client record transfers; and assessment and analyses
7. Chat rooms/electronic discussion groups – group counseling; self-help; and support

B. Specific Examples of Information on the Internet

1. Career Change Aids

These sources can help with finding information and options. Other links to counseling and guidance services can also be found at:

- America's Career InfoNet – <http://www.acinet.org>
- Riley Guide – <http://www.rileyguide.com/careers.html>
- Occupational Outlook Handbook – <http://www.bls.gov/ocohome.htm>
- JobStar's Career Resources – <http://jobstar.org/tools/career/>

2. Search Engines

Search engines search databases for keywords retrieved from/located in Internet documents. It is possible to locate information on any topic (occupation or industry) or employer. Each search engine is different in how it works and what it indexes, so two or three should be used in a search, and the results should be compared. The following is a list of some of the available search engines:

- AltaVista – <http://www.altavista.com>
- HotBot – <http://hotbot.lycos.com>
- WebCrawler – <http://www.webcrawler.com>
- Excite – <http://www.excite.com>
- Metacrawler – <http://www.metacrawler.com>
- Google – <http://www.google.com>

3. Online General Resource Guides

Sites or online documents dedicated to a specific topic or industry identify much more specific industry and employer information:

- Hoover's Online (business reference directory)
<http://www.hoovers.com>
- Scholarly Societies Project (professional and scholarly associations)
<http://www.lib.uwaterloo.ca/society/overview.html>
- Riley Guide – <http://www.rileyguide.com/search.html>
- The Argus Clearinghouse is a good source for guides
<http://www.clearinghouse.net>
- Britannica is also a good source for guides – <http://www.britannica.com>

4. Vacancies

- Professional's Job Finder – <http://jobfindersonline.com>
- Non-profit and Education Job Finder – <http://jobfindersonline.com>
- The National Job Hotline Directory – Access More Than 3,000 employment hotlines

5. Wage and Salary Information

In addition to information found on the above listed sites, surveying job listings in many job banks will provide additional information:

- <http://www.rileyguide.com/salary.html>.
- JobStar Salary Surveys – <http://jobstar.org/tools/salary/>
- Careerjournal.com – <http://www.careerjournal.com>
(look under Salaries and Profiles)
- America's Career InfoNet – <http://www.acinet.org>

CAREER AND VOCATIONAL COUNSELING FOR SPECIAL POPULATIONS

I. Women in the Workplace

More women are in today's workplace than ever before due to the rising divorce rate and the declining birth rate. Besides having to deal with financial difficulties, inadequate child-care facilities, and role conflicts, these women are frequently underskilled for the current workplace and are not equipped to handle any discrimination and harassment they may encounter.

A. Needs-Based Socio-Psychological Model

Astin (1984) proposes **four constructs** in a woman's Need-Based Socio-Psychological Model of career choice and work behavior:

1. **Motivation** in the form of three primary needs (survival, pleasure, and contribution) is the same for both sexes. Work-defined activity intended to produce or accomplish something has the capacity to satisfy these needs.
2. **Sex-role socialization**, whereby social norms and values are inculcated through play, family, school, and early work experiences.
3. **The structure of opportunity** includes:
 - a. economic conditions
 - b. the family structure
 - c. the job market
 - d. the occupational structure
 - e. other environmental factors that are influenced by:
 - scientific discoveries
 - technological advances
 - historical events
 - social and intellectual movements
4. **Work expectations**, including:
 - a. perceptions of one's capabilities and strengths
 - b. the options available
 - c. the kinds of work that can best satisfy one's needs

B. Developmental Model of Occupational Aspirations

1. Gottfredson (1981) proposed a Developmental Theory of Occupational Aspirations. She believes one's self-concept becomes increasingly differentiated and complex as a child matures.
2. Persons create their own cognitive maps of acceptable alternatives based on their view of where he or she fits into society.
3. Gottfredson portrays the developmental stages and their effects on occupational aspirations by describing **four major stages**:

Stage 1: Orientation to size and power (ages 3-5)

Stage 2: Orientation of sex roles (ages 6-8)

Stage 3: Orientation to social valuation (ages 9-13)

- Awareness of social class
- The development of preferences for level of work
- Differences in preferences by social class and ability level
- Circumscription of range of preferences

Stage 4: Orientation to the internal, unique self (ages 14 +)

- Perception of self and others
- Specification of vocational aspirations

C. Factors Affecting Women

1. Tokenism – The low proportion of one sex in a workplace dominated by the opposite sex. Efforts to change the composition of the workforce have centered on legally removing discrimination barriers and on changing the career aspirations of women.
2. Stereotypes – Restriction of individuals to traditionally defined male and female appropriate careers.
 - Efforts to eliminate this barrier have been notably unsuccessful to date.
3. Lack of Role Models – Due to historical discrimination, few women have succeeded to positions not traditionally filled by women (managers, pilots, mechanics, etc.). Girls do not have the example of numerous successful women to encourage them in non-traditional roles.
 - This situation is slowly changing as barriers are broken by particular individuals.
4. Discontinuities in Female Career Development – For women, the primary source of discontinuity is children. This is seen as a paramount barrier to occupational upward mobility.
5. Dual Roles – Traditionally, women have had sole responsibility for maintenance of the home and the children. This workload constituted a significant barrier to their success in an outside work environment. As women make a greater commitment to education and training, their willingness to accept full responsibility for household tasks including child rearing is decreasing (Benin and Agostinelli, 1988).

6. Dual Career Families – are families in which both man and woman are wage earners.
 - a. Rapoport and Rapoport (1971) describe an **identity tension line**, a point beyond which the violation of sex-role socialization becomes uncomfortable for the individual, both male and female.
 - b. In general, the higher the status of woman's occupation, the more she expects her spouse to assume the shared burden of household tasks and parenting (G.W. Bird, G. A. Bird, & Scruggs, 1984).
 - c. The benefits of a **dual-career marriage** have been enumerated by Wilcox-Matthew and Minor (1989):
 - Feelings of self-worth, accomplishment, and control
 - More roles in which to define success
 - Marital solidarity
 - Higher standard of living
 - Child-care support policies in some employing organizations
 - More egalitarian roles
7. Self-efficacy – This tenet suggests that because of differential socialization, women lack strong expectations of personal efficacy for a variety of career-related behaviors.
 - a. Hackett and Betz (1981) suggest that women who believe they are incapable of performing certain tasks (low self-efficacy) limit their career mobility and restrict their career options.
 - b. Women are also hindered in developing self-efficacy when they are in work environments that are less responsive to women than men and that do not reward their accomplishments equally with men.
 - c. Self-efficacy is also hindered by a history of restricted options and underutilization of abilities. Thus, women who judge their efficacy to be low tend to give up, procrastinate, and avoid certain career decisions.

8. Sexual harassment (Sharf, 2002)

- Men who have tendencies toward sexual harassment are likely to link sexuality with social dominance.
- It is estimated that half the female population of the U.S. has been harassed.
- Harassment is rarely reported by males except at the least severe level.
- Single women report more harassment than married women.

a. Types of Sexual Harassment

Gender harassment – verbal remarks and non-touching behaviors that are sexist in nature

Seductive behavior – inappropriate sexual advances, attempts to discuss sexual interest or the person's sex life

Sexual bribery – sex for a raise, higher grade, or for a promotion

Sexual coercion – threatened punishment (firing, demotion, failing the course) and then coercing sexual activity

Sexual assault – forceful attempts to touch, grab, kiss, fondle, etc.

b. Responses to sexual harassment (Sharf, 2002)

- Internally focused: minimizes the behavior; deny it's really offensive; excuses the offender; take the blame themselves
- Externally focused: avoiding or placating the offender; confronting the harasser and stating the behavior is unwelcome; aggressive remarks; getting support from the organization; getting social support from friends and family

c. Four stages of reacting to harassment

- (1.) Confusion and self-blame – upset by their inability to stop the harassment, may assume responsibility for being harassed
- (2.) Fear and anxiety – attendance at work and concentration at work may suffer; may have personal safety issues
- (3.) Depression and anger – may feel despair over her progress at work; situation may worsen after the complaint is filed
- (4.) Disillusionment – resolution of the complaint may be a long hard process and not always successful; many organizations are not supportive

II. Careers for Persons with Disabilities

A person with disabilities is one who is usually considered to be different from a normal person - physically, physiologically, neurologically, or psychologically - because of accident, disease, birth, or developmental problems. Fine & Asch (1988) suggest that persons with disabilities should be viewed as a minority group; as such, their problems are considered not so much physical as social and psychological, and problems are caused not so much by the disability itself as by the environment.

In vocational rehabilitation (Herr and Cramer, 1996), counselors will engage in some or all of the following activities:

- vocational testing
- vocational assessment (work sampling, vocational evaluation)
- counseling
- work adjustment training
- prevocational activities
- skills training
- employment preparation
- job development
- job referral and placement
- post-placement counseling

Herr (1982) delineates a list of knowledge and skills necessary for counselors who work frequently with persons with disabilities:

A. Knowledge

1. Federal and state legislation, guidelines and policies dealing with exceptional persons
2. Rigors of exceptional persons
3. Types of classification, diagnostic tools, or processes and their limitations vis-à-vis work potential or skill
4. Informal assessment procedures for determining interests, values, and goals
5. Characteristics of different types of exceptionality, their causes, and their likely effects upon work behavior
6. Opportunities available in the local labor market for persons with different types of skills and difficulties
7. The meaning of functional limitation and its use in counseling
8. Models of career development applicable to congenitally or adventitiously disabled people
9. The effects of social stigma, labeling, and stereotyping on the self-concept of exceptional persons
10. Characteristics of handicapped people related to employment skills, training programs, and potential occupational and educational opportunities
11. Ways of working with other specialists to facilitate a comprehensive approach to career exploration, career preparation, and career placement of exceptional persons
12. Examples of job redesign by which employers can accommodate the capabilities and/or functional limitations of various types of exceptionality
13. Methods of developing individual educational programs or individual employment plans
14. Fears, concerns, and needs of parents or spouses of exceptional persons and ways to work with the total family unit
15. Models of developing daily living, mobility, job search, and work skills
16. Reference materials and directories pertinent to different categories of exceptionality

B. Abilities/Skills

1. Ability to interpret and advise about legislation, policy, guidelines, and rights that affect exceptional persons and their family members
2. Ability to use diagnostic and informal assessment procedures with exceptional persons
3. Ability to assess functional limitations and use them in helping clients engage in occupational exploration and career planning
4. Ability to apply knowledge of career development theory to assist in the analysis of self-concept portrayal or developmental task deficits of individual clients
5. Ability to provide effective individual and group counseling of persons of different types of exceptionality and their families
6. Ability to work with other specialists in team approaches to clients for educational or employment planning and placement
7. Ability to work with employers in developing job restructuring for different types of exceptional persons
8. Ability to plan and implement different types of skill-building workshops or experiences necessary for employability and work adjustment

III. Counseling the Older Worker

Herr and Cramer (1996) have suggested the following goals for counseling the older worker:

1. Provide support in building and maintaining positive attitudes toward one's worth and dignity
2. Explore possible retraining and other avenues for improving employment opportunities
3. Assess the actual reasons for employment difficulties
4. Assist individuals in accurately gauging their present state of motivation, the expectations they hold for future employment, and their perception of themselves as workers
5. Especially with white collar occupations, help the individual to consider the relative importance of such factors as salary, use of abilities, status, amount of responsibility, security, opportunities for advancement, chance to make a contribution, and so on.
6. Assist in developing job-seeking behaviors, if necessary
7. Provide placement and follow-up services if no other opportunities exist in the area served; refer to appropriate agencies and institutions if placement services are available.

IV. Career Counseling of the Culturally Different

Herr & Cramer (1996) have proposed guidelines for career counseling of the culturally different:

1. Counselors should, above all, possess all the generic counseling knowledge, skill, understanding, ability, and behavior thought to be appropriate in any helping relationship.
2. Counselors should recognize their own attitudes and values as these impinge on counseling specific ethnic and racial groups; they must work to ensure that these internal frames of reference do not form road blocks to successful counseling.
3. Counselors should be aware of the cultural context from which individuals come, but they should not assume that individuals are bound by that culture. Clients are first and foremost individuals and only secondarily representatives of a specific racial or ethnic group.
4. Counselors should understand what aspects of career helping may need special attention with specific culturally different groups.
5. Counselors must help minorities understand and internalize the fact that they do have a choice in career development; that given certain decisions and behaviors, certain consequences are likely to occur.
6. Counselors should help culturally different individuals understand that although they may encounter discrimination, they cannot be discouraged by it or consider themselves perpetual victims of it.
7. Counselors must be sure that they understand which deficits and discontinuities in the career development of the culturally different are consequences of socioeconomic class and which are the result of membership in some specific racial or ethnic group.

PLANNING CAREER DEVELOPMENT PROGRAMS

Herr & Cramer (1996) recommend viewing vocational guidance as a total system of interacting techniques and personnel that facilitate the individual's acquisition of knowledge, attitudes, and skills leading to effective career behavior.

The goals of career guidance (the individual's acquisition of knowledge, attitudes, and skills) will require different methods in each of the following environments:

- Educational
- Agency
- Workplace

Recognition of the uniqueness of each of these environments will lead to both accountability and program effectiveness. Advantages of such an approach are summarized (Walz and Benjamin, 1984) below:

- A. **A developmental emphasis** – This gives program planners the opportunity to design a proactive delivery system that anticipates needs and problems and develops appropriate strategies for dealing with them.
- B. **Effective use of available resources** – Components of the delivery system can be tailored to desired outcomes.
- C. **Manageability to change and innovation** – Clearly stated goals and objectives and modes of delivery make it easier to locate difficulties and find areas needing change.
- D. **Relative ease of evaluation** – Specific standards for judging behavioral change allow for more objective evaluation and highlight areas for new methods.
- E. **Avoidance of faddism** – Clarity provides a source of insulation against faddism or opportunistic responses to catchy ideas that have not been tested systematically.
- F. **Promotion of community effort** – Knowledge fosters a higher degree of articulation by community members and stimulates them to find ways that they can be involved.

Outcomes-based project management of this kind is seldom taught in counselor training programs.

Career counseling is a combination of very concrete, measurable behaviors and cognitive change and as such allows a more specific definition of methods and expected outcomes.

The systematic approach requires a classic management cycle of planning, executing, monitoring, and adjusting, which are not typical counselor skills.

CAREER EDUCATION

Career education is the provision of structured knowledge and skills programs appropriate for individual development stages.

Career education is **distinct from career counseling**, which focuses on active intervention to effect career choice and fit.

The focus of **career education** (Zunker, 1998) is:

1. Elementary School – Systematic provision of knowledge and skills throughout the curriculum; create positive attitudes toward self and opportunities, feelings of competence, and ways school experience can be used to explore and prepare for the future
2. Junior High School – Acknowledge the transitional character of this period and help students understand the consequences of curricular and course choices made now - and planned for in senior high school - so that later options will not be prematurely closed
3. Senior High School – Stimulate career development, provide treatment, and aid placement; provide specific planning of next stages in education and work; values clarification of life roles as a worker, a consumer, a leisurite, and a family member; assuming responsibility for decision making and its consequences
4. Adult – Facilitate the continuance of a life-long process of career development; provision of knowledge, skills, and specific planning of the next stages in education, training, and work; values clarification of life roles; help individuals reach their own potential

GENERAL JOB MARKET INFORMATION

There are profound changes in the world of work as a result of technology and its effect on individual workers, the effect of globalization as demonstrated by the attack on the U.S. on September 11, 2001, and economic reverses due to the corporate failures such as ENRON. A person's success in the emerging economy will depend on many factors, **flexibility** being the most important.

A. Flexibility

According to Herr and Cramer (1996), the elements of personal flexibility are basic academic skills and adaptive skills.

- Herr and Cramer propose that entrepreneurial behavior, which consists of acquiring understanding of systems, risks, and change, will be an important ingredient in the future in many aspects of the global economy. Additionally, flexibility will be important in government, service industries, manufacturing, education, and will be critical in both domestic and international economic development. Organizations will find workers who think like entrepreneurs more valuable while the world of work will be looking for people who can deal with change and find new solutions to problems.

B. Unemployment Rate

The economic downturn over the last two years has resulted in massive layoffs. This means there is a large pool of adult job seekers who may or may not be getting needed career counseling.

C. White-Collar Jobs

The July 2002 labor statistics, from the U.S. Bureau of Labor Statistics (BLS, 2002), reports that 59.9 percent of all workers (July 2002) were in white collar, or knowledge, jobs. These include managerial, technical, sales, and support categories. These people are particularly able to think with ideas and deal with change.

D. Blue-Collar Jobs

The 40.1 percent of blue-collar jobs are comprised by service, production, equipment operators, and farm laborers.

E. Education Status

Increasing education, also a key part of ability to learn and be flexible, reflects important movement in the new economy. BLS reports that 61 percent of all workers have at least some college education. Only 9.4 percent were reported not to have at least a high school diploma.

F. Aging of the Work Force

The **aging of the work force** is another trend shifting our attitudes towards career. In 1996, one in five Americans was over 55 years of age; by 2010, it is projected that one in every four will be in that age range. This produces some issues that need to be addressed:

- The ability of the Social Security system to provide support to such a large body of retirees is in doubt.
- This large number of retirees also puts major pressure on private retirement funds, which will have to fund much larger liabilities for their larger numbers of retirees.
- This demographic shift has implications for an expected/acceptable retirement age, which is already moving from the expected 65 years of age to 70 years and beyond.

G. The Hidden Market

There is a hidden market which responds to its own rules and reduces the individual's ability to move from a lower socioeconomic class to a middle or upper class, wealthy one. This market is characterized by **hidden rules** (patterns of thought, social interaction, and cognitive strategies) and unspoken cues. Major differences, based on more than money, exist between those in generational poverty and the middle class. Some of these differences are:

- **Financial differences** – Money and purchasing power
- **Emotional Resource differences** – The ability to exercise self-control and possessing the stamina to weather negative situations and feelings
- **Mental differences** – Having the abilities and skills to process information and use it to negotiate daily life
- **Spiritual differences** – Believing in a higher power that provides guidance and an understanding for life's purpose, helps from seeing oneself as hopeless but rather as capable, worthy, and valuable
- **Physical differences** – Being able-bodied and mobile, leads to self-sufficiency
- **Support Systems differences** – Having friends and family who have valuable knowledge to share and who will back a person in times of need
- **Role Model differences** – Knowing and having access to adults who are nurturing and appropriate in their behavior towards children, and who do not demonstrate habitually self-destructive behavior
- **Knowledge of Hidden Rules differences** – Having an awareness of the unspoken understandings and cues that allow a person to fit into a certain group

AMERICAN WORK ETHIC

The meanings attached to work differ not only across groups and cultures but also across time (Herr & Cramer 1996). Maccoby and Terzi (1981) propose that there have been **four major work ethics** throughout American history and that elements or residuals of each of these still exist:

- A. **The Protestant Ethic** – driven to work and could not tolerate unethical and undisciplined behavior
- B. **The Craft Ethic** – oriented toward savings and self-sufficiency, independence, and self-control
- C. **The Entrepreneurial Ethic** – risk taking; the exploitation of opportunities and a dislike of regulations that stifle free enterprise
- D. **The Career Ethic** – other directed, striving to get ahead, to become more attractive and valuable in the marketplace

Maccoby and Terzi indicate that there is a **fifth** ethic rapidly emerging:

- E. **The Ethic of Self-fulfillment** – seeking challenge, growth and work that is not so consuming that it denies a place for other parts of life

ETHICAL GUIDELINES FOR CAREER COUNSELORS

I. National Career Development Association Guidelines (NCDA, 2002)

NCDA Guidelines (<http://ncda.org>, 2002) exist for the following areas:

- A. **Career Counseling Competencies** – Delineates minimum competencies for those professional career counselors at or above the Master's degree level of education
- B. **Guidelines for the Use of the Internet for Provision of Career Information and Planning Services** – Includes provider qualifications, access, content, appropriateness for client, additional client support, referral, use of assessments, ethics, and unacceptable counselor behavior
- C. **Career Development Policy Statement** – Includes NCDA's definition of career development with basic considerations for grades K-6, grades 7-9, grades 10-12, and adults
- D. **Consumer Guidelines for Selecting a Career Counselor** – Designed to help consumers of career counseling understand and select career services
- E. **Ethical Standards** – Presents standards of practice for the following areas: counseling relationship, measurement and evaluation, research and publication, consulting, private practice, and procedures for processing ethical complaints
- F. **Guidelines for the Preparation and Evaluation of Career and Occupational Information Literature** – Guidelines for publishers and consumers of career and occupational print literature; includes a reviewer checklist
- G. **Guidelines for the Preparation and Evaluation of Video Career Media** – Guidelines for publishers and consumers of video career media; includes a reviewer checklist
- H. **Career Software Review Guidelines** – Guidelines for publishers and consumers of career software; includes a reviewer checklist

II. Competencies

In order to work as a professional engaged in Career Counseling, an individual must demonstrate minimum competencies in eleven (11) areas:

1. Career Development Theory
2. Individual and Group Counseling Skills
3. Individual/Group Assessment
4. Information/Resources
5. Program Management and Implementation
6. Consultation
7. Diverse Populations
8. Supervision
9. Ethical/Legal Issues
10. Research/Evaluation
11. Technology

III. Record Keeping

- Records of the counseling relationship, including interview notes, test data, correspondence, audio or visual tape recordings, electronic data storage, and other documents are considered professional information.
- This information should not be considered a part of the records of the institution or agency in which the NCDA member is employed unless specified by state statute or regulation.
- Revelation to others of counseling material must occur only with the expressed consent of the client.
- Career counselors must make provisions for maintaining confidentiality in the storage and disposal of records.
- Career counselors providing information to the public or to subordinates, peers, or supervisors have a responsibility to ensure that the content is stated in general, broad terms.
- Unidentified client information should be accurate and unbiased and should consist of objective, factual data.

IV. Electronic Storage

- NCDA members must ensure that data maintained in electronic storage is secure.
- The data must be limited to information that is appropriate and necessary for the services being provided and accessible only to appropriate staff members involved in the provision of services by using the best computer security methods available.
- Career counselors must also ensure that electronically stored data is destroyed when the information is no longer of value in providing services.

LAWS GOVERNING DISCRIMINATION

Taken from the Cornell School of Law Legal Information Institute (2002)

I. The Equal Pay Act

The Equal Pay Act amended the Fair Labor Standards Act in 1963. The Equal Pay Act prohibits employers and unions from paying wages based on gender. It provides that where workers perform equal work in jobs requiring "equal skill, effort, and responsibility and performed under similar working conditions," they should be provided equal pay. The Fair Labor Standards Act applies to employees engaged in some aspect of interstate commerce or all of an employer's workers if the enterprise is engaged as a whole in a significant amount of interstate commerce.

II. Title VII of the Civil Rights Act of 1964

Title VII of the Civil Rights Act of 1964 prohibits discrimination in many more aspects of the employment relationship. It applies to most employers engaged in interstate commerce with more than 15 employees, labor organizations, and employment agencies. The Act prohibits discrimination based on race, color, religion, sex or national origin. Sex includes pregnancy, childbirth, or related medical conditions. It makes it illegal for employers to discriminate in hiring, discharging, compensation, or terms, conditions, and privileges of employment. Employment agencies may not discriminate when hiring or referring applicants. Labor organizations are also prohibited from basing membership or union classifications on race, color, religion, sex, or national origin.

III. The Nineteenth Century Civil Rights Acts

The Nineteenth Century Civil Rights Acts (amended in 1993) ensure all persons equal rights under the law and outline the damages available to complainants in actions brought under the Civil Rights Act of 1964, Title VII, the American with Disabilities Act of 1990, and the Rehabilitation Act of 1973.

IV. The Age Discrimination in Employment Act (ADEA)

The Age Discrimination in Employment Act (ADEA) prohibits employers from discriminating on the basis of age. The prohibited practices are nearly identical to those outlined in Title VII of the Civil Rights Act. An employee is protected from discrimination based on age if he or she is over 40. The ADEA contains explicit guidelines for benefit, pension, and retirement plans.

V. The Rehabilitation Act

The purpose of the **Rehabilitation Act of 1973** is to "promote and expand employment opportunities in the public and private sectors for handicapped individuals" through affirmative action programs and the elimination of discrimination. Employers covered by the act include agencies of the federal government and employers receiving federal contracts over \$2500 or federal financial assistance. The Department of Labor enforces section 793 of the Act which refers to employment under federal contracts. The Department of Justice enforces section 794 of the Act which refers to organizations receiving federal assistance. The Equal Opportunity Employment Commission (EOEC) enforces the Act against federal employees. Individual federal agencies promulgate regulations pertaining to the employment of the disabled.

VI. The American with Disabilities Act (ADA)

The American with Disabilities Act (ADA) was enacted to eliminate discrimination against those with handicaps. It prohibits discrimination based on a physical or mental handicap by employers engaged in interstate commerce and state governments. The type of discrimination prohibited is broader than that explicitly outlined by Title VII.

VII. The Equal Opportunity Employment Commission (EOEC)

The Equal Opportunity Employment Commission (EOEC) interprets and enforces:

- The Equal Payment Act
- The Age Discrimination in Employment Act
- Title VII, Americans With Disabilities Act
- Sections of the Rehabilitation Act

The Equal Opportunity Employment Commission was established by Title VII.

VIII. Rehabilitation (Physical) Requirement Guidelines (Wolmed, 2002)

Doctors usually release disabled patients from physical therapy to work with restrictions. The restrictions are to limit the amount of physical stress the patient will face so that the employer does not force him or her into labor which will re-injure them. The restrictions are communicated in terms of frequencies:

- Occasional – 1-33% of the time at work or 1-32 repeats per day
- Frequently – 34-65% of the time at work or 33-200 repeats per day
- Constant, or Continuously – 67-100 % of the time at work or greater than 200 repeats per day

The categories within the restrictions are as follows:

- Sedentary – the patient may lift 10 lbs. occasionally
- Sedentary-light – The patient may lift 15 lbs. occasionally and 8 lbs. frequently.
- Light – The patient may lift 20 lbs. occasionally and 10 lbs. frequently.
- Light-Medium – The patient may lift 35 lbs. occasionally, 15 lbs. frequently, and 7 lbs. constantly.
- Medium – The patient may lift 50 lbs. occasionally, 25 lbs. frequently, and 10 lbs. constantly.
- Medium-Heavy – The patient may lift 75 lbs. occasionally, 35 lbs. frequently, and 15 lbs. constantly.
- Heavy – The patient may lift 100 lbs. occasionally, 50 lbs. frequently, and 20 lbs. constantly.
- Very-Heavy – The patient may lift >100 lbs. occasionally, >50 lbs. frequently, and >20 lbs. constantly.

RESUME WRITING AND COVER LETTERS

I. Resume Writing (Bolles, 1998; Herr & Cramer, 1996)

A. What Research Indicates

- Research has shown that only one interview is granted for every 200 resumes received by the average employer.
- Research also indicates that a resume will be quickly scanned rather than read. Ten (10) to twenty (20) seconds is all the time an applicant has to persuade a prospective employer to read further.
- What this means is that the decision to interview a candidate is usually based on an overall first impression of the resume, a quick screening which so impresses the reader and convinces them of the candidate's qualifications that an interview results.
- As a result, the top half of the first page of a resume will be crucial. By the time the prospective employer has read the first few lines, the resume has either caught his/her attention, or it has failed.
- In essence then, a resume is an advertisement. It should have the same result as a well-written ad: to get the reader to respond.

B. The Purpose of a Resume

The resume is a tool with several specific purposes:

1. To organize the applicant's thoughts and opinions about him or herself
2. To organize the applicant's thoughts about what kind of job he or she is seeking
3. To form an information basis for applications and interviews
4. To win an interview. If it doesn't, it isn't an effective resume.
5. A resume is an advertisement, nothing more, nothing less:
 - It doesn't just tell what the applicant has done but makes the same assertion that all good ads do: "If you buy this product, you will get these specific, direct benefits."
 - It convinces the employer that the applicant has what it takes to be successful in this new position or career.
 - It is so pleasing to the eye that the reader is enticed to pick it up and read it. It "whets the appetite," stimulates interest in meeting the applicant and learning more about him or her.
 - It inspires the prospective employer to pick up the phone and ask the applicant to come in for an interview.
6. Also, a resume:
 - Allows the applicant to make and the employer to read an inventory of your experiences and abilities.
 - Can be a requirement for a personal interview.
 - Tells the applicant's story his or her way.
 - Represents the applicant when he or she is not present.
 - Is information an employer expects with mail inquiries.
 - Is a direct-mail advertising piece.
 - Is a detailed calling card.

II. Cover Letters

A cover letter should accompany each resume sent. It will be viewed as the first "writing sample" and should be complementary to the information on the resume.

A. Two Basic Types of Cover Letters

1. A Prospecting/Introductory Letter – An introductory letter sent to an employer to inquire about potential job or internship openings.
2. An Application Letter – Forward an application letter to an employer in response to an actual job or internship listing.

B. Purpose of a Cover Letter

The purpose of a cover letter is to:

1. Capture the employer's (or reader's) interest
2. Invite the recipient to read the resume in depth
3. Secure an interview (for information or employment purposes)

C. Initiate Contact

A cover letter is designed to initiate contact (for a variety of purposes) with:

1. An employer to introduce the applicant and inquire about job or internship possibilities.
2. An employer to apply for an actual position.
3. An alumnus, family or friend to ask for an informational interview.
4. A professor or former supervisor to request a letter of recommendation.

D. General Characteristics and Recommendations

1. In general, your cover letter should be no longer than one-page composed of 3-4 paragraphs and should be word-processed in a professional letter format.
2. Each letter should be well written and unique.
3. Communicate:
 - Why the applicant is writing
 - How he or she learned about their organization
 - What he or she wants them to know about him or her and his or her background
 - Why they should invite him or her in for an interview
4. Use good quality paper that matches the resume and envelope.
5. Address the letter to a specific name and title (ideally the hiring manager).
6. If a specific person alerted the applicant to a position or employer, include that individual's name and title (i.e., "Eleanor Smith, an Account Manager with your agency).

STRESS

Stress-related illness costs the U.S. \$300 billion a year in medical costs and lost productivity (Sharf, 1996).

Stress Experience – occurs when a person is confronted by a demand that is perceived to exceed the emotional or the physical resources available to effectively respond to it.

Shore (1992) classifies stress at work into three categories:

- Biochemical stress – exposure to chemical and biological substances that interfere with normal body functioning
- Physical stress – including noise, ventilation, heat, pace of production, and time of shift
- Psychosocial stress – potential or actual conflict between a worker and some aspect of the worker's company, including conflicting job demands, negative patterns of supervision and communication, lack of respect and recognition, racism, and sexism

I. “Type A” Behavior

Stress is induced by type A behavior (Zunker, 1998; Friedman & Rosenman, 1975). Type A behavior consists of 5 components:

- A. A continuous struggle to accomplish or to achieve more or to participate in more events in less time, frequently in the face of opposition - real or imagined - from other persons.
- B. Is dominated by covert insecurity of status, hyperaggressiveness, or both.
- C. Struggle eventually fosters a sense of time urgency, a distortion of the Puritan legacy of improving the time.
- D. Hyperaggressiveness usually shows itself in the easily aroused anger called free-floating hostility.
- E. If the struggle becomes severe enough and persists long enough, it may lead to a tendency toward self-destruction.

II. “Type B” Behavior

Type B behavior refers to an absence of the five components comprising “Type A” Behavior.

III. “Types” of Problem Employees

Neff (1985) has identified several types of problem employees and the characteristics of their work psychopathology. He separates them into the following types of workers:

Type I includes people who appear to have a major deficiency in work motivation; they have a negative conception of the role of work.

Type II includes individuals whose predominating response to the demand to be productive is manifest fear and anxiety.

Type III includes people who are predominantly characterized by open hostility and aggression.

Type IV includes people who are characterized by marked dependency.

Type V includes people who display a marked degree of social naiveté.

HISTORY OF THE AMERICAN COUNSELING ASSOCIATION

(American Counseling Association, online – www.counseling.org)

The American Personnel and Guidance Association (APGA) was established in 1962. At a joint convention of the following groups, APGA was established in hopes of providing a larger professional voice:

- The National Vocational Guidance Association (NVGA)
- The National Association of Guidance and Counselor Trainers (NAGCT)
- The Student Personnel Association for Teacher Education (SPATE)
- The American College Personnel Association

The APGA later changed names in 1983 to the **American Association of Counseling and Development (AACD)**.

On July 1, 1992, the AACD changed its name to the **American Counseling Association (ACA)** to reflect the common bond among association members and to reinforce their unity of purpose (ACA, 2002).

ADDITIONAL CAREER DEVELOPMENT TERMS

(Zunker, 1998)

1. **Avocation** – An activity pursued systematically and consecutively for its own sake with an objective other than monetary gain, although it may incidentally result in gain.
2. **Burnout** – a depletion of an individual's physical and mental resources due to excessive strivings to attain some unrealistic goal imposed by one's self or by the values of society.
3. **Career** – the lifelong sequence of work, educational, and leisure experiences.
4. **Career Change**
 - a. **Mid-Life Career Change** – Changing jobs due to a midlife transition (ages 35 – 45) in the interest of reaping the benefits of experience, such as pay raises, job advancement, and the like. Such change may necessitate additional training and supplemental experience. Midlife career change falls into two groups:
 - voluntary
 - involuntary
 - b. **Late Life Changers** – These are individuals that have taken early retirement or have been forced into a retirement mandated by law.
5. **Career Counseling** – A largely verbal process in which a counselor and counselee(s) is in a dynamic and a collaborative relationship, focused on identifying and acting on the counselees' goals. The counselor employs a repertoire of diverse techniques or processes to help bring about self-understanding, understanding of behavioral options available, and informed decision making in the counselee, who has the responsibility for his or her own actions.
6. **Career Development** – The total constellation of psychological, sociological, education, physical, economic, and chance factors that combine to shape the career of any given individual over the life span.
7. **Career Education** – The totality of experiences by which persons acquire knowledge and attitudes about self and work and the skills by which to identify, choose, plan, and prepare for work and other life options potentially constituting a career.
8. **Career Guidance** – A systematic program of counselor-coordinated information and experiences designed to facilitate individual career development and, more specifically, career management.
9. **Career Intervention** – Any activity designed to enhance a person's career development or to enable that person to make more effective career decisions.
10. **Career Ladder** – increasingly responsible, lucrative, and prestigious jobs over a total career.

11. **Career Lattice** – A combination of a career ladder with lateral moves to positions of comparable responsibility, reward, and prestige over a total career.
12. **Career Management** – the actions required to control one's career according to a plan.
13. **Displaced Homemaker** – Women over the age of 35 who have been out of the labor force for an extended period of time.
14. **Displaced Worker** – People who have lost jobs due to changes in corporate structure (downsizing, mergers, or acquisitions).
15. **Economically Disadvantaged** – The economically disadvantaged fall into three categories:
 - a. The chronically poor
 - b. The unemployed or newly disadvantaged
 - c. The underemployed (over-qualified)
16. **Functional Limitation** – The lack of ability to execute or perform customary roles and common daily endeavors as the result of impairment.
17. **Job Satisfaction** (Miller and Mattson) – results when one's work choice is consistent with the dominant motivational pattern or thrust which comes from a particular interest, ability, or personality trait exhibited by a person. Such consistency yields job satisfaction. Lack of consistency produces **burnout**.
18. **Job** – a group of similar positions in a particular work setting; “How I describe what I do.” (See Occupation) “I’m a math teacher; oncologist; counselor.”
19. **Leisure** – Time free from required effort or for the free use of abilities and pursuit of interests.
20. **Occupation** – a group of jobs so similar in nature that a person successful in one could move to another without great difficulty. “The group I associate with.” (See Job) “I associate with educators; medical doctors; mental health professionals.”
21. **Reentry Woman** – a displaced female worker who is reentering the job force.
22. **Stress Experience** – occurs when a person is confronted by a demand that is perceived to exceed the emotional or the physical resources available to effectively respond to it.
23. **Supply and Demand Curve** – the comparison of supply of a commodity to demand for it. Typically, as supply increases, demand decreases.
24. **Underemployment** – Being underemployed means being in a job which requires skill or knowledge at a lower level than that which an individual is capable. It thus deskills the employee and offers limited possibilities for personal achievement. It lacks a positive meaning. O’Toole (1981) argued that when doing “bad work” (a negative factor, an unpleasant necessity) individuals cope with each unrewarding work by creating a sense of community.

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Chapter 13

Social, Cultural, & Family Issues

SOCIAL, CULTURAL AND FAMILY ISSUES

NCE – Chapter 13

Chapter Outline

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SOCIAL, CULTURAL AND FAMILY ISSUES

NCE – Chapter 13

PART I – SOCIAL AND FAMILY ISSUES

I. Sociologists and Their Contributions

A. Solomon Asch

Asch explored peer conformity by having subjects choose which of three comparison lines was the same length as a standard line. The correct answers were so obvious that individuals working alone reached 98 percent accuracy. The subjects gave their judgments in the presence of seven to nine of their peers. Unknown to the single naïve subject in each group, all other group members were confederates of the experimenter. In seven of twelve trials, as the confederates announced their judgments one by one, they unanimously gave the wrong answer. The Asch experiments clearly demonstrated that people feel pressure to conform to group standards even when they know the standards are wrong.

B. D. R. Atkinson

Atkinson suggests that the primary barrier to effective cross-cultural counseling may be the **traditional counseling role** itself, being nonegalitarian, office bound, and using intrapsychic models that are not congruent with the thought processes of many minority groups. Atkinson feels that **shared similar experiences** are not necessary for effective counseling, since our experiences as human beings are remarkably similar. His findings disputed Sue's research about termination rates and causes.

C. Emory S. Bogardus

Bogardus authored a book entitled **Sociology**. The social group as the center of human interaction, as the matrix of social processes and social change, and as the realm within which personalities originate, develop, and mature, is the theme of this book. The social group is considered to be the main laboratory of sociology.

D. Leon Festinger

1. Festinger is associated with the Theory of Social Comparison. The primary assumptions are as follows:
 - a. First, individuals are driven to evaluate their abilities and opinions.
 - b. Second, people first attempt to make these evaluations through objective, nonsocial means, but if those means are unavailable, they are likely to compare themselves with others.
 - c. Third, individuals are likely to choose for comparison someone close to the opinion or ability in question.
2. **If comparisons are with divergent others**, the evaluations are imprecise or unstable. **Comparisons with moderately different others**, however, produce changes in individuals' evaluations of their own or others' abilities or opinions. The changes ensure uniformity in the group and reinforce stable and precise evaluations.

E. William McDougall

McDougall was influential in early social psychology.

F. Margaret Mead

Mead's research suggested that one's core identity emerges from the individual's ability to perceive and to share the attitudes and the definitions of others toward one's self.

G. Frank Parsons

Parsons is considered the Father of Guidance. He was the first one to focus heavily on sociocultural issues and led the way for vocational guidance in community agencies.

H. P. B. Pederson

Pederson developed the **Triad model** for training cross-cultural counselors, where the trainee participates in role playing with a client from a different cultural background as well as with an **anti-counselor** (a role player similar to an alter ego who is culturally similar to the client). Pederson identified as a barrier to counseling the fear that a counselor would indoctrinate a client to get the client to become more like the dominant culture.

I. Stanley Schachter

Schachter proposed that our environment as well as thought processes contribute to the type of emotional experience that we have in any situation. According to Schachter, the emotion we recognize we are experiencing comes from a number of interacting events.

J. Muzafer Sherif

Sherif made use of a visual illusion that makes a stationary pinpoint of light in a dark room appear to move. Sherif asked subjects in his experiments to estimate how far the light moved. In a group setting, individuals gave initial estimates that were similar to one another and rapidly converged on a single group estimate. When tested alone, they continued to use their group standard to guide their personal estimates. They had influenced one another's very perception of the light so that they believed the group estimate to be the most accurate judgment of reality. The Sherif experiment suggests that conformity pressures in groups are subtle and extremely powerful.

K. D. W. Sue

Sue found that minorities are less likely to seek counseling. The **termination rate** after the first interview is **50 percent** for minorities and **30 percent** for Anglos. Sue is a proponent of cross-cultural counseling, encouraging counselors to develop broad frameworks rather than focusing on each minority group separately. Sue also warned counselors that traditional counseling approaches often violate the basic philosophy of life held by Native Americans. His work revealed that lower-class clients (as compared to middle-class clients) tend to receive inferior treatment and are more likely to be diagnosed as having mental illnesses.

L. Zimbardo

Zimbardo did a prison study that demonstrated that people alter their behavior to fit their assigned roles.

II. Research Procedures, Principles, and Strategies

A. Empirical Research Procedures

1. Identify the topic
2. Review the literature
3. Formulate a hypothesis
4. Collect and analyze the data
5. Disseminate the results

B. Research Principles

1. Objectivity
 - a. The first principle in conducting family research is objectivity.
 - b. It is difficult to maintain objectivity in family studies because every researcher is part of a family and brings a set of values/suppositions to the process.
 - c. Objectivity requires a researcher to recognize these preconceived suppositions and acknowledge how these ideas might influence the research process.
2. Replication
 - a. Research is conducted and reported in a manner that enables others to reproduce the study.
 - b. A study must be reported in detail as to how it was conducted.
 - c. Future researchers may want to repeat the study to corroborate the findings or to adjust the sample to compare results to the original data.
3. Reliability
 - a. Research depends on instruments to measure the variables being studied.
 - b. An assessment must prove reliable and valid so that the collection and analysis of the data is trustworthy.
 - c. The reliability of an instrument is established when the assessment yields similar results in repeated use and with varying populations.
4. Validity
 - a. An assessment instrument is valid when it accurately measures what the researchers designed it to measure.
 - b. Validity is based on the comparison of results with already established standards of measure.

C. Research Strategies

1. Self-Reported Data

- a. Research based on interviews or questionnaires given to a select group of respondents is considered self-reported data.
- b. One concern of using self-reported data is the accuracy and the honesty of the respondents.
- c. Distortions may be due to inaccurate recall, selective perception, or social desirability.
- d. Surveys are ideal for studying a large group of people and produce results that are consistent and comparable.
- e. Interviews allow respondents to reply in their own words and to elaborate on their answers.

2. Observational Research

- a. Observational research provides accounts of authentic behavior but makes it difficult to replicate the data.
- b. Two types of observational research are participant and clinical observation.
 - **Participant observation** is when the researcher is part of the natural setting and takes an observer role.
 - **Clinical observation** is usually conducted in a controlled setting such as a counseling center when the observer is identified as such.

3. Experimental Research

- a. Research conducted under controlled conditions is labeled experimental.
- b. The approach involves the use of an independent variable, a dependent variable, a study group, and a control group.
- c. The desired analysis of an experiment is to determine if there is a cause and effect relationship between the variables or just a correlation that cannot be used to cite causality.

4. Archival and Content Analysis

- a. This type of research is based on documents rather than people sources.
- b. Public documents such as records of birth, death, and marriage, diaries, speeches, and newspaper articles are possible sources.
- c. Personal documents like letters and autobiographies are also useful sources.
- d. The consistency and accuracy of the documents studied is a primary concern to the researcher.

5. Secondary Analysis of Data

- a. The process of using existing data sets rather than collecting primary research is known as secondary analysis of data.
- b. The previously collected data is used to answer a new research question not part of the original study.
- c. The benefits of secondary analysis are advantageous use of high-quality data and generalizable findings based on a large national sampling.

III. Social Psychology Theories

Social Psychology is the study of the effects of social environments on the psychological functioning of individuals.

A. Role Theory

1. Definition of a Role

a. **Role theory** provides one framework for studying human development.

- Bee and Mitchell's (1984) definition of a role as "the content of a position or the behavioral implications of occupying that position" has been generally accepted.

b. Their work also laid out three essential characteristics of roles:

- Each culture defines the roles within its own system. These roles may change within that culture.
- Each role requires a partnering role to complete its function. Such complementary pairs might be employer-employee, parent-child, etc.
- An individual will fulfill more than one role at a time resulting in possible role conflicts.

2. Role Integration

As individuals find themselves having to fulfill more than one role at a time, friction and conflict between the roles can occur as the individual must choose between "competing" roles. Appropriate decisions about which roles to occupy at any given time lead to **role integration** which is essential for good mental health.

3. Recognized Roles

a. Age Roles

Developmental theorists view human development as a **progression through timeframes**. Examples would be Erikson's (1963) proposed eight developmental **stages** and Levinson's (1978) five life span **eras** (More on this in Normal Human Growth and Development).

b. Sex Roles

- i. No one today can deny that men and women's "job descriptions" are shifting; recent research agrees.
- ii. Female and male sex roles are seen as basically distinct through childhood and early adulthood, yet the roles seem to become similar among older adults (Bee & Mitchell, 1984).
- iii. Criticism of the traditional division of sex roles includes the assertions that such distinctions:
 - restrain human potential by limiting individuals to behavior deemed sex-appropriate
 - confers more status, power, and desirability on the male role (Van Hoose & Worth, 1982)
- iv. Bem (1975) maintains that people will function more effectively in complex societies once they can act as **androgynous** individuals; that is, they can act independently of stereotyped sex roles.

c. Family Roles

i. Family life-cycle stages

While the number of single-parent families and stepfamilies in this society continually increases, most people still experience a particular, distinct set of roles as they become adults and have children. These are known as family **life-cycle stages** (Carter & McGoldrick, 1999):

(KNOW IN THIS ORDER)

- (a) Young adulthood
- (b) Couples with no children
- (c) Couples with children
- (d) Family with adolescent children
- (e) Launching phase
- (f) Families in later life

ii. Daniel Levinson

Levinson suggests four stages:

- (a) The Early Adult Transition (ages 17-22). A young man is now on the boundary between pre-adulthood and early adulthood.
- (b) Age 30 Transition (ends at 33). This stage frequently begins with a vague uneasiness, a feeling that something is missing or wrong in one's life and that some change is needed if the future is to be worthwhile.
- (c) The Mid-life Transition (ages 40-45). This transition is a bridge between early adulthood and middle adulthood.
- (d) Later Adulthood

Levinson wrote *Seasons of a Man's Life*. His suggestion of a mid-life crisis for men ages 40-45 was later discredited by additional research.

iii. Carol Gilligan

Gilligan wrote a landmark book, *In a Different Voice* (1982), which offered an alternative to Kohlberg's model of moral development. Kohlberg's study was based on a 20-year longitudinal study of 84 males so is criticized by Gilligan as not being inclusive of the moral development of women.

Stage 1: Individual survival and self-interest.

Transition: Awareness of other's needs and interpretation of self-interest as "selfish."

Stage 2: Responsibility to others. Goodness is equated with self-sacrificial giving.

Transition: Awareness of legitimacy of one's own needs and responsibility to oneself as well as to others.

Stage 3: Balance of self-care and care for others.

Integration: Morality of care and nonviolence.

Gilligan theorized that girls were reared to be nurturing, empathic, concerned with the needs of others, and to define their sense of "goodness" in this way.

d. Work Roles

- (a) An individual's work years usually begin in the teenage years and continue on into retirement, thus filling most of a person's life.
- (b) These work roles provide more than a financial livelihood since the majority of people in most societies base their personal identities on the character, essence, or nature of their work.
- (c) Such personal definition fulfills both psychological and social needs.

B. Other Social Theories

1. Balance Theory

- a. Heider's suggests an early consistency or balance theory.
- b. This approach is concerned with an individual's perception of the relationships between himself/herself and two other elements in a triadic structure.
- c. The other elements are often another person and another object.
- d. The attitudes in the structure are designated as either positive or negative.
- e. The goal of assessing the structure of a triad is to ascertain whether the relationships between the actors and the other elements are balanced or consistent.
- f. According to Heider (1958), a balanced triad occurs when all the relationships are positive, or two are negative and one is positive, and the elements in the triad fit together with no stress.

2. Social Exchange Theory

- a. Social exchange theorists borrow ideas from economics. They argue that all interaction is an "exchange of goods, material and non-material," in which individuals try to maximize their profit by reaping as many rewards as possible while incurring the fewest possible costs.
- b. An example is that of a student missing class and borrowing the notes of another student. Both students will assess the costs and rewards and base their decision on the maximum profit they can attain with as little cost as possible. It is costly in terms of embarrassment and discomfort to ask another for notes but rewarding to have the material for an exam. For the other student, it may be flattering to be asked for notes and may be useful when thinking of future returned favors. It may be costly, however, in that the student may feel used.

3. Congruity Theory

- Osgood et al. (1957) proposed a measurement technique that was the first correlation between a theory and a scaling technique. According to the theory, attitudes can be quantified along an evaluative scale, from extremely negative to neutral to extremely positive. Congruity theory holds that when change in evaluation or attitude occurs, it always occurs in direction of greater congruity.
- An example of this occurrence is when two individuals (Sam and Fred) have a positive attitude toward each other and the same perspective toward another individual (Joe), they are said to be in congruence. However, if Fred changes his perspective toward Joe so that he now has a negative attitude toward him, Sam must decide whether to continue to have a positive attitude toward Joe or change his attitude to coincide with that of Fred. Until he does so, the situation is said to be one of **incongruity**.
- Basically, the principle says that there is a tendency for the evaluation of one or both individuals to change so that the evaluations are more similar.

4. Cognitive Dissonance Theory

- a. Dissonance refers to a negative arousal brought about by one's inconsistent thoughts or actions or both.
- b. This translates to the following assumptions:
 - i. If one has opposing thoughts or behaviors, or both, this brings about an aversive state of tension, akin to a drive state like hunger or thirst.
 - ii. This tension motivates the individual to seek relief by eliminating the tension by changing
 - either a thought or attitude to make it consonant with the opposing thought or behavior, or
 - one's behavior, to make it consonant with the opposing behavior or thought.
 - iii. Because it is often much easier to change one's thoughts rather than one's behaviors, these are typically the elements that get modified by the person in dissonance reduction.

For example, Festinger talked about the dissonance experienced by most smokers at some point in their lives. Smokers engage in behavior that is harmful to their health. This is at odds with our desire to avoid harming ourselves. This arouses tension in the individual. The smoker could reduce the tension by changing his or her behavior or by changing the way he or she thinks about the smoking behavior. As mentioned above, changing behavior is often more difficult than changing cognitions. Smokers, therefore, typically eliminate their dissonance by changing their thoughts about smoking. They may: (1) disbelieve the validity of the health consequences of smoking or distort the information about smoking or (2) convince themselves that "we all die of something, and I might as well die doing something I enjoy." All of these changes in thoughts eliminate the dissonance for the smoker.

IV. Social Context Issues

Understanding the following issues has proven relevant to counselors as they assist clients in dealing with their environment. (Note: The following brief observations have been made based on many sources including the U.S. Census Bureau and U.S. Labor Department statistics.)

A. Women in the Workplace

1. By 1978, for the first time in U.S. history, half of all adult women were working or were actively seeking work outside of the home.
2. By 1984, 56 percent of all minor children had employed mothers, and 47 percent of women with children one year old or younger were in the work force.
3. One quarter of all employed women hold jobs in only 22 of 500 occupation categories identified by the Bureau of the Census.
4. Two fifths of working women are the sole head of household.
5. Trends toward postponing marriage and childbearing and having fewer children have increased the number of women in the labor force.
6. Earnings gap: On an annual basis, women working full time earn 74 percent of what men earn. As the percentage of female workers in an occupation increases, the earnings of both sexes in that occupation decrease.
7. Work Stability: The average man will enter or re-enter the labor force three times during his lifetime and will spend 38.5 years in the labor force. Women enter or re-enter the labor force 4.5 times for a total of 27.7 years.
8. Between 1970 and 1980, the proportion of women managers rose from 18 percent to 31 percent.
9. Well-educated women are more likely to seek employment than less educated ones. Seventy-eight percent of women who are college graduates work; less than half of adult women who are not high school graduates are in the labor force.
10. 1982 was the first year since 1947 that the men's unemployment rate was higher than the women's. The trend is expected to continue.
11. Women in the work force are experiencing an increase in the physical symptoms of stress such as hypertension and heart disease.

B. Teen Pregnancy

1. Physical maturation and sexual awareness are occurring at an earlier and earlier age.
2. Our country is experiencing one million teen pregnancies a year.
3. 94 percent of unmarried teen mothers keep their babies.
4. 50 percent of unmarried teen mothers will become pregnant again within three years.
5. 1 in 10-20 teenage boys will father a premarital pregnancy.
6. Pregnant teens marry only 10 percent of the time.
7. The divorce rate for parents younger than 18 years of age is 3 times greater than for those who have their first child after 20 years of age.
8. The divorce rate among teens within the first five years of marriage is 60 percent.
9. Infants born to adolescent mothers are more likely to have a low birth weight and a higher chance of mortality.
10. Teenage mothers often drop out of school, fail to gain employment, become dependent on welfare, and lack parenting skills.

C. Aging

1. The average life expectancy is 75 years of age.
2. 20 percent of the population is between the ages of 45 and 65; by the year 2030, this group will represent 30 percent of the population.
3. 35 percent of the population is over 45 years of age; 50 percent will be over 45 by the year 2030.
4. 15 percent of the population is now over 65 years; 20 percent of the population will be over 65 by the year 2030.
5. The over-75 age group is the fastest growing segment of the U.S. population.
6. 80 percent of the elderly that need mental health services will not be served.
7. The best predictors of retirement adjustment are financial security and health.
8. The elderly face myths of aging such as the following: (1) intelligence declines in old age and (2) the elderly are incapable of sex.
9. **Terminal drop theory** refers to the change in activity and cognitive functioning seen shortly (up to 2 years) before death. A decrease in intelligence is apparent due to this drop.

D. Grief and Loss

1. **Grief** is the normal intense emotional state associated with the loss of someone (or something) with whom (or which) one has had a deep emotional bond.
2. **Loss** refers to many kinds of deprivation.
3. Kubler-Ross (1969) identifies five common stages in the grieving process
(KNOW IN THIS ORDER):
 - denial
 - anger
 - bargaining
 - depression
 - acceptance

E. Disabilities

The **Education for All Handicapped Children Act**; Public Law 94.142 (1975); abbreviated as PL94.142, decreed that educational and counseling services be made available for handicapped children. Also know IDEA – Individuals with Disabilities Education Act.

F. Abuse

1. Abuse may be physical, verbal, and/or sexual.
2. Victims can be of any age including both the young and old, of either sex, of any race or ethnic group, and from any social group, status, or rank (Vacc & Loesch, 1987).
3. The needs of abused clients are being met by such establishments as rape victim advocacy programs, foster care arrangements, parent aid programs, and family violence shelters, including women's shelters.

G. Substance Abuse

Competent counselors recognize substance abuse in their clients and then use appropriate counseling skills or enlist help from others (referrals) to help these clients.

H. Interpersonal Attraction

1. Factors said to enhance interpersonal attraction are close proximity, physical attraction, and similar beliefs.
2. Those perceived as attractive are assumed to have other positive traits.
3. **Sleeper effect** is a term that refers to interpersonal influence. In immediate reaction studies, high credibility sources tend to be more effective persuaders than low credibility sources. Over time, however, source effects appear to become diminished.
4. Regardless of culture, a popular individual is believed to have good social skills.

I. Conflict

1. Four Types of Conflict

Psychologists identify four basic types of conflict. They are:

a. Approach-Approach Conflict

In this conflict, an individual must choose between two attractive stimuli or circumstances. It is the conflict that is the least stressful, although in situations where one needs to make important decisions (e.g. deciding between two good career opportunities), it can result in some increased stress. It typically results from limitations on one's time, space, energy, and personal and financial resources.

b. Approach-Avoidance Conflict

In this conflict, a person must make a decision that involves a single stimulus or circumstance in which positive and negative characteristics are present. (Example: Wanting to eat, but not wanting to gain weight.)

c. Avoidance-Avoidance Conflict

In this conflict, the individual must choose between two unattractive or undesirable stimuli or circumstances. (Example: Washing a sink-full of dishes or vacuuming the house. Preparing income taxes or studying for the State's counselor exam.)

d. Double Approach-Avoidance Conflict

In this situation, the individual experiences the rise of conflict from having to choose between two or more goals. Each goal has both positive and negative aspects. (Example: One's attraction to a larger newer house but higher payments and a smaller older house but smaller payments.)

2. Robber's Cave Experiment

Robber's Cave Experiment was an experiment on conflict between ingroups and outgroups. It offered the following results:

- a. Conflict would lead groups to adopt a hierarchical internal structure and would cause the "ingroup" to think of the "outgroup" in a derogatory manner.
- b. Conflict would produce loyalty to members of the "ingroup" and hostility to the "outgroup."
- c. Conflict would lead people to overvalue performance of the "ingroup" relative to the "outgroup."
- d. Hostility would be overcome only when the two groups found themselves in a situation in which they had a super-ordinate goal.

J. Aggression

1. Social Learning Theory

Social learning theorists believe **aggression is learned**.

a. Albert Bandura

- Albert Bandura's social learning theory of aggression has been most influential.
- Bandura suggests that much of human development is based on learning by observing how other people behave.

b. Patterson, DeBaryshe, and Ramsey

- Patterson, DeBaryshe, and Ramsey studied maladaptive social learning processes present in families of aggressive children.
- They found parental use of poor disciplinary measures and inadequate monitoring of their children's activities.

c. Olweus

Olweus identified a number of child rearing factors that are conducive to creating bullies:

- caretakers with indifferent attitudes toward the child
- permissiveness of aggressive behavior by the child
- the use of physical punishment and other power-assertive disciplinary techniques (Olweus, 1978)

d. Economic conditions

Some research suggests that very poor economic conditions correlate very highly with aggression.

2. The Frustration-Aggression Theory

a. **The Frustration-Aggression Theory** by Dollard, Doob, Miller, Mowrer, and Sears (1939) stated that:

- all acts of aggression are the result of previous frustration;
- all frustration leads to aggression. But, some frustrations do not yield aggression, and some aggression is not the result of a prior frustration.

b. Many contemporary scholars believe that if a frustrating event is fully justified, the frustrated person would show no residual inclination to aggress. However, Berkowitz (1969) claimed that even fully justified frustration can produce aggressive tendencies.

3. The Milgram Experiments

The power of legitimate authority to compel obedience was demonstrated in the Stanley Milgram experiments.

- a. As a part of an apparent learning study, a scientist-experimenter ordered subjects to give increasingly strong electric shocks to another person. The subjects were told they controlled a shock generator which had labels for increasing levels of shock: “danger-severe shock” and “XXX.”
- b. The victim (a confederate who received no actual shocks) protested, cried out, and complained of heart trouble.
- c. Despite the confederate’s protest, 65 percent of the subjects complied with the scientist-experimenter and shocked the victim all the way to the 450 volt maximum. It was suggested that people typically do as they are told by legitimate authorities.

K. Spirituality and Religions

1. Spirituality

Spirituality involves personal beliefs, such as those about an ultimate human condition or set of values toward which we strive, a supreme being, or a unity with nature and the universe.

2. Religions

Religions are organized belief systems. They include shared beliefs and values regarding God and involvement in a religious community (McGoldrick, 1998).

3. Use of Client's Religion and Spirituality

- a. Counselors historically have avoided dealing with the religion and the spirituality of their clients. This is due to both ethical and personal inhibitions. The code of ethics warns against imposing one's personal values and beliefs on a client. Counselors are also discouraged from practicing beyond their scope of training.
- b. The beliefs, religion, and spirituality of clients, however, are deeply imbedded in their cognitions and behavior. The successful counselor will utilize these aspects of the individual to the advantage of the client rather than avoid them. They can be used as resources in times of adversity and pain.
- c. By addressing these aspects of the client, the counselor respects them as people, honors the diversity of their beliefs and practices, and promotes their personal growth and welfare.

4. Intrinsic vs. Extrinsic Religiosity

Griffith and Rotter (1999) suggest that it is vital that a counselor assess the religiosity of a client to determine whether it is intrinsic or extrinsic.

- a. **Intrinsic religiosity** is religious belief that relates to all of life and is unprejudiced, tolerant, mature, integrative, unifying, and meaning-endowing. This type of religiosity can enhance the spiritual well-being of an individual.
- b. **Extrinsic religiosity** is said to be compartmentalized, prejudiced, exclusionary, immature, utilitarian, and self-serving. They state that extrinsic religiosity is used as a defense mechanism as opposed to intrinsic religiosity which encourages growth and wellness.

V. Leading Causes of Death in the U.S.

(National Center for Health Statistics, 1999)

A. Adults

(KNOW IN THIS ORDER)

1. Heart Disease
2. Cancer
3. Strokes

B. Adolescents

(KNOW IN THIS ORDER)

1. Accidents (unintentional injuries) (usually Alcohol related)
2. Homicide
3. Suicide

C. Infants

(KNOW IN THIS ORDER)

1. Congenital and chromosomal abnormalities
2. Disorders related to short gestation and low birthrate
3. SIDS (Sudden Infant Death Syndrome)

D. Durkheim

1. **Durkheim** explains the sociological approach to suicide as a reaction to societal pressures and influences.
2. Durkheim identified three types of suicide:
 - egoistic
 - anomic
 - altruistic

VI. Contemporary Family Living Patterns

The family is the basic unit of any society. While marital and family customs differ around the world, counseling professionals recognize the implications of one's being in or out of this unit of social and personal interaction.

A. Types of Households

For two hundred years, the U.S. federal government has asked citizens to report where they live and with whom. These collective living arrangements are classified as households. While numerous kinds of households exist, only two basic types of households are categorized: family and non-family.

1. Family Households

Axelson (1985) defines *family* as a group of two or more people related by birth, marriage, or adoption who reside together. The 2000 Census reported that 68 percent of all U.S. households fit this category. Axelson (1993) has further categorized types of family and non-family living arrangements:

- a. Traditional nuclear family – Includes only the wife, the husband, and their own or adopted children.
- b. Single-parent family – Includes either a single, widowed, or divorced father or mother and his or her own children.
- c. Blended family – Results from the marriage of a divorced man and/or a divorced woman and includes his and/or her children.
- d. Extended family – Includes other relatives or in-laws who share the household with the nuclear family.
- e. Augmented family – Includes non-relatives, such as boarders, friends, or other long-term guests, who share the household with the family and have some influence on family life.
- f. Shared household – Includes two or more relatives or non-related persons of the same or opposite sex living together.

2. Non-family Households

According to the 2000 Census, non-family households represent 32 percent of all U.S. households. These households include persons living alone (81%) or with non-relatives.

B. Special Household Considerations

1. Domestic partnerships

While both the increased growth and the visibility of the homosexual population are evident, accurate figures are impossible to attain. A conservative estimate would be that the homosexual minority comprises more than 10% of our population.

2. Homeless Persons

Three patterns of homelessness have been defined for the growing homeless population:

- temporary
- episodic
- chronic

3. Intergroup Marriages

Mixed or interracial marriage is still the exception in the U.S. but the numbers are increasing dramatically. If parents of mixed marriages help their children identify with both their heritages, emotional consequences are lessened (Axelson, 1993).

4. Homosexual Lifestyle

a. Family Structure

- i. Homosexual couples do not have the same supports, institutionalized social sanctions, and acceptability as do heterosexual couples. There is an absence of religious or legal bonds and rituals for gay couples.
- ii. There are a complex number of systems involved: a) The homosexual family system created by the couple; b) The family of origin of each family member; c) The homosexual community within which the family is embedded; and d) the mainstream community in which the family must function.
- iii. Gender role socialization is reflected in differences in emotional intimacy, sexuality, and power. These differences are expected to diminish as the gender roles are challenged.
- iv. Lesbian relationships have the capacity for fusion, especially in reaction to systemic pressures. This may be viewed as a strength or weakness, depending on the ego strength of the women involved. Lesbians form friendships or affectional commitments prior to sexual relationships. Sexuality is much more likely to be inseparable from relational desires for women than for men.
- v. Because the maintenance of the relationship must be done by men in gay couples, and because many men rely on sexual contact as a vehicle for emotional intimacy, sexual relations are a significant component of gay relationships. Gay couples have sex more frequently than heterosexual couples and multiple sexual partners are common.
- vi. Gender differences in egalitarian values are similarly reflected in some gay and lesbian organizations, where men tend to value formal structure and hierarchy, and women often value informal networking and equality of power.
- vii. The structure of homosexual families includes many variations. The primary parenting unit may be a single parent, dyad, or three or more. The children may be from previous heterosexual marriages, adoption, or artificial insemination/sperm donation (Scrivner & Eldridge, 1995).
- viii. Many family members have difficulties accepting a gay son or a lesbian daughter, and temporary or permanent estrangement after disclosure is not uncommon. Robinson, Walters, and Sheen (1989) have documented a five-stage grief process (shock, denial, guilt, anger, and acceptance) that parents go through in coming to accept a gay son or a lesbian daughter.

b. Counselor Awareness

- i. In working with family members who resist accepting a gay son or a lesbian daughter, it is important to assess how much of the resistance is due to the son or daughter's affectional orientation and how much is a function of the child's attempt to separate and to differentiate from the family.
- ii. The counselor must effectively work with both the extended gay family and the biological family members of a person with AIDS in order to help both systems deal with the extensive emotional and physical care-taking demands of the situation.
- iii. The counselor needs to assess the extent to which the presenting problems are related to a gay or a lesbian identity such as concerns about disclosure, lack of role models or guiding rituals, discrimination, and anti-gay violence.
- iv. Some guidelines: Be aware of heterosexism; use gender free language; educate yourself and your clients about lesbian and gay experience; identify and use a consultant; learn about local support networks; become aware of relevant ethical issues (Scrivner & Eldridge, 1995).

c. Cultural Factors

- i. In the late 20th century American society, gay relationships evoke more intense negative and controversial reactions from mainstream society than just about any other form of relationship behavior (Okun, 1996).
- ii. Homosexual communities have become more visible in the past two decades. A sense of oppression underlies a sense of shared community and mutual support, which, in turn, underlies the effectiveness of the gay liberation movement.
- iii. The individual's development of his/her homosexual lifestyle is summarized as a progression through eight stages:
 - Sensitization;
 - Identity Confusion;
 - Identity Comparison;
 - Identity Tolerance;
 - Identity Acceptance;
 - First Relationships;
 - Identity Commitment and Pride; and
 - Identity Synthesis (Scrivner & Eldridge, 1995).

PART II – CULTURAL ISSUES

I. Approaches to Viewing Cultures/Clients

A. Etic-Emic Approach

1. Etic

- a. Culture is studied and understood in terms of how it differs from or is similar to other cultures on shared dimensions (e.g. family function, the single universal definition of mental health, etc).
- b. Culture is examined from an **external** viewpoint; cultural differences are seen as surface variations of underlying structures shared by all.
- c. A counselor who is “etic” would make a study of such things as a group’s speech patterns, economic or political structure, and social/religious makeup, so as to more effectively help them.
- d. Freud and Ellis are Etics with their concepts postulated to **apply to everyone**.

2. Emic

- a. Culture is studied from **within** the system. Comparisons are made to internal structures and not to external systems or theories. Culture is seen as a phenomenon to be understood from a position within the system.
- b. An “emic” counselor would become directly immersed in the culture by living within it and by believing that mental health is “relative”; what is “crazy” in one society is “sane” in another.
- c. The emic view **emphasizes individual differences**.

B. Autoplastic-Alloplastic Approach

1. Autoplastic

Autoplastic changes are changes in oneself; therefore, **clients** are encouraged to **change themselves** to accommodate the external circumstances.

2. Alloplastic

Alloplastic changes are changes in the external environment; therefore, a **client’s outside world** is manipulated to effect change.

C. World View

Ibrahim (1991) developed the following scale to assess World Views:

1. Human nature: Good, bad, or a combination
2. Social relationship: Lineal-hierarchical, collateral-mutual, or individualistic
3. Nature: Subjugate and control, live in harmony, or accept power and control
4. Time orientation: Past, present, or future-oriented
5. Activity orientation: Being, being-in-becoming, or doing

II. Cross-Cultural Dimensions

A. Cross-Cultural Counseling

1. Culturally competent practice

- a. Cross-cultural counselors will display knowledge of the different cultures of both their clients and themselves.
 - They will have knowledge of the impact of one's own life experiences, values, biases, and limitations.
 - They will have knowledge of culturally specific behaviors as related to degrees of normalcy.
 - They will have the ability to identify and to express their own values, biases, and limitations, including the role of their own life experiences.
- b. Successful counselors will be culturally sensitive, provide appropriate counselor environments, and refer to appropriate community resources.
 - They display the ability to use relevant environmental, community, and institutional resources.
 - They demonstrate knowledge of resources for education and training to increase competence regarding specific cultural and diversity groups.
 - They have the ability to integrate knowledge of specific cultural and diversity groups into practice.
 - They have the ability to respect differences in life experiences and choices.
 - They have skill in assessing and creating a counseling environment for cultural sensitivity and appropriateness.
 - They show skill in assessing the cultural and the linguistic appropriateness of community resources.
 - They have skill in assessing and accurately communicating cultural factors that may have potential for harm.
- c. Cross-cultural counselors have skill in consulting and working with indigenous network support systems. Examples include medicinal, spiritual, and botanical systems.
- d. These counselors utilize techniques for bridging cultural differences that include selecting appropriate treatment interventions in keeping with the client's cultural context.

- e. Utilization of microskills is evident in a culturally relevant and linguistically appropriate manner by culturally competent counselors.
 - They have knowledge of multicultural and diversity models of assessment.
 - They have knowledge of the influence of culture and diversity on assessment.
 - They demonstrate skill in differentiating the appropriate use of theories and techniques with multicultural clients.
 - They have the ability to adapt their counseling approach to specific clients.
 - They portray skill in implementing appropriate treatment in conjunction with multicultural and diversity models.
 - They have skill in eliciting the client's perception of normalcy and in differentiating behaviors as related to degrees of normalcy.
 - They have knowledge of multicultural counseling.
 - They show knowledge of appropriate individual, couple, family, and group counseling models and strategies for working with diverse populations.
 - They are able to convey information in a non-judgmental manner.
 - They have the ability to use microskills such as encouragement, confrontation, and empathy in a culturally relevant and linguistically appropriate manner.
 - They have skill in identifying and using specific language nuances.
 - f. They are able to write in an objective and culturally competent manner.
2. Two legislative activities that influenced multicultural counseling were:
- a. **Brown vs. the Kansas Board of Education**

Only after the 1954 Supreme Court decision of **Brown vs. the Kansas Board of Education** and the Civil Rights movement in the 1960s did professional members begin to recognize and reference the need to attend to various cultural groups. The urgent question was whether counseling should deal exclusively with normal development needs or include concerns of a broader psychological nature. Special groups began to demand that counseling become relevant to their particular needs.
 - b. **The Civil Rights Act of 1964**

The Civil Rights Act of 1964 (PL 88-352) prohibited discrimination based on gender, race, religion, or national origin.

3. **AMCD** is the Association for Multicultural Counseling and Development. They are a division of ACA (American Counseling Association).
4. **Multicultural (or intercultural) counseling** refers to preparation and practices that integrate multicultural and cultural-specific awareness, knowledge, and skills into counseling interactions. It is said to be the **fourth force** of counseling theory.
 - a. Research indicates that in most cases, clients prefer a counselor of the same race and similar cultural background.
 - b. **Therapeutic surrender** means the client psychologically surrenders himself or herself to a counselor from a different culture and becomes open with feelings and thoughts. Factors helpful in promoting therapeutic surrender are rapport, trust, listening, conquering client resistance, and self-disclosure.
 - c. Therapeutic style with cross-cultural counseling
 - Cultures who value authority figures will expect a directive counselor who gives homework. They will view passivity by the counselor in a negative manner.
 - Middle and upper-class clients in the U.S. want a counselor who helps them work the problem out on their own.
 - Rogerian person-centered counseling has been used more than other model to help promote understanding between cultures and races.
 - d. The **drop-out rate** of ethnic-minority clients is about 50% following the first session.
5. **Assessment**
 - a. **Cultural context** must impact a multicultural counselor's diagnosis. Cultural relativism has an effect on diagnosis by influencing the expectations of the counselor. A counselor most likely expects more rigid standards of social conformity from someone of his/her own culture.
 - b. Assessment needs to take into account the contributions of minority status, political oppression, and low socioeconomic status on individual differences in test performance. Mainstream assessment may be less appropriate for racial and ethnic minority individuals than for White, middle-class, educated people.
 - c. There are two types of assessment methodology: unstructured and structured. Both can demonstrate cultural biases.
 - d. Some criteria of the DSM-IV refer to behaviors, beliefs, and feelings that are not pathological in certain minority cultures. An example is a belief in evil spirits by traditional Puerto Ricans. This normal cultural phenomenon would infer pathology based on DSM-IV criteria (Pope-Davis & Coleman, 1997).

B. Counseling Barriers

Cross-cultural counseling presents distinct differences between the counselor and the client. Cultural, racial, ethnic, and/or socio-economic environments must be appraised and accounted for in the counseling encounter. As discussed by **Atkinson, Morten, and Sue** (1983), there are three barriers to all cross-cultural counseling situations:

1. Language differences
2. Class-bound values
3. Culture-bound values

Clients prefer a counselor of the same race and similar cultural background.

C. American Ethnic Minorities

The main ethnic minority groups in the U.S. include:

1. American Indian or Alaska Native
2. Black or African Americans
3. Hispanic Americans
4. Asian Americans

Counselors involved with ethnic minority clients should be knowledgeable of the characteristics of these ethnic groups and be able to incorporate such information into their practices.

1. American Indian or Alaska Native

a. Facts

- While American Indians are generally viewed as being all one ethnic group, the truth is that there are many ethnically distinct tribes.
- The 2000 Census reported 2.4 million American Indians or Alaska Natives living in the United States.
- Native Americans emphasize harmony with the environment, have a deep respect for natural resources, and have an ability to be in nature rather than filling time with activity or filling space with possessions, as ends in themselves.
- The following statement sums up the Native American philosophy: “We honor a man for what he has done for the people rather than for what he has done for himself.”
- A sense of eye contact may indicate lack of respect.
- Native Americans experience a high rate of alcoholism.
- The suicide rate is high, peaking in the 20s or early 30s.

b. Family structure

- The extended family structure is typical of American Indians. They view grandparents as the main caregivers and providers of training and discipline. Cousins are referred to as brother and sister.
- Many Indian cultures do not have a term for in-law; a daughter-in-law is called a daughter; a sister-in-law, a sister. When one marries into an Indian family, no distinctions are made between natural and inducted family members. Families are blended, not joined, through marriage.
- Extended family responsibility for child welfare is a central aspect. There is considerable attachment of the child to the entire group.
- In some tribes, the father is considered the teacher. Therefore, he will send his child to be disciplined by a specially designated tribal member so as not to destroy the teaching relationship.
- Child care is distributed within a network of caring people, including upward to 100 relatives who are considered to be responsible family members.
- Community responsibility is a key aspect of Indian tribal networks, diminishing the importance of the nuclear family as a separate unit.

c. Attitudes toward authority figures (including counseling)

- In some native cultures, it is considered disrespectful for one relative to directly mention the name of another. A Lakota woman may refer to her father-in-law as “he” rather than speak his name (McGoldrick, Giordano, & Pearce, 1996).

d. Counseling Issues

- Reluctance to engage in consideration of emotional issues with strangers is likely.
- Contracting or other strategies concerning appropriate behavior may be seen as manipulative.
- High rates of noncompliance are seen with treatments that do not include family and community networks in intervention; therefore, individual counseling is not very useful.
- Native cultures value listening. Long periods of silence by Indian clients can be confusing for the counselor. Silence may connote that the client is forming thoughts, that the client is waiting for signs that it is the right time to speak, or that the client is showing respect.
- The non-Indian counselor may treat silence, embellished metaphors, and indirectness as signs of resistance, when actually they represent forms of communication. Presenting problems typically include substance abuse (particularly alcoholism), family violence, abuse and neglect of children, issues of disloyalty for leaving the reservation, and issues associated with low socioeconomic level.
- Appropriate therapeutic techniques include respectful patience, home-based counseling, peer support groups, cooperation with the indigenous system, and directive interventions. (McGoldrick, Giordano, & Pearce, 1996).

e. Acculturation

- Today, many Indians are reclaiming the life-affirming traditions of their cultures and using them to combat grave social ills caused by 500 years of oppression.
- Some Indians may struggle to maintain their cultural identity in a foreign environment, while others may try to recapture nearly extinct languages.
- Indian time is not limited to a specific minute or hour. It may encompass days, months, or even years and is geared to personal and season rhythms rather than being ordered and organized by external mechanical clocks and calendars. Technologically-minded White society’s encroachment makes it difficult to maintain this highly satisfying approach to time management; this contributes to the culture shock Indians feel when returning or entering this society after being on the reservation (McGoldrick, Giordano, & Pearce, 1996).

f. Spirituality

- Native American Indians view all things as having life, spiritual energy, and importance. They hold a fundamental belief that all things are connected, and that the universe maintains a balance and cycle of the spiritual energy (Garrett & Garrett, 1994).
- Harmony with all natural forces is a way of life. This peaceful alliance includes every natural force from the serene mist in the forest to devastating natural disasters (Sutton, C. & Broken Nose, M., 1996).
- A person should live in harmony with these spiritual relatives in the same manner that they strive for harmony with their human relatives (Sutton, C. & Broken Nose, M., 1996).
- Spiritual being requires that one finds his/her place in the universe. The search for the right path to follow, his/her specific connection to the universe, should not be impeded or dictated by another (Garrett & Garrett, 1994).
- Each individual has a unique balance between the Four Directions - spirit, nature, body, and mind. Harmony is sought between the Four Directions, ourselves, and our universe (Garrett & Garrett, 1994).

2. Black or African Americans

a. Facts

- A high suicide rate is present among black male adults along with depression.
- Black infant mortality rates are considerably higher than for Whites.
- Feelings of powerlessness can be perpetuated by the system.
- Some research indicates a growing Black middle-class moving away from traditional professions (teaching, ministry) and into business, the sciences, and technology.
- Blacks experience a high rate of hypertension.
- Blacks experience a high rate of sickle-cell anemia.
- Five strengths (Hill, 1972) of blacks include the following:
 1. The adaptability of family roles
 2. Strong kinship bonds
 3. A strong work orientation
 4. A strong religious orientation
 5. A strong achievement orientation

b. Family structure

- Extended kin relationships are treated like immediate family. Family members are expected to provide assistance in times of crisis.
- A broader network of kinship remains the key to coping with pressures of societal oppression.
- Male identity is linked to ability to provide for the family; however, this is limited by discrimination.
- Women tend to be regarded as the all-sacrificing strength of the family. Their identity as a mother is very important. An egalitarian relationship typically exists due to the need of the mothers to work outside the home (McGoldrick, Giordano, & Pearce, 1996).
- It is common for a child to be informally adopted and reared by extended family members who are better off than the child's parents.
- A strong racial identity is instilled in male children in order to compensate for the negative and destructive messages they are given by society (McGoldrick, 1998).
- In some urban Black communities, boys and girls are given the message that womanhood and manhood are attained by having a child, whether the needed social maturity is evident or not.
- Media and literature often represent Black men as unable to fulfill the positions of husband and father; a tough, not tender, image is promoted.
- There are a high number of single parent homes with a female as the head of the family.
- The Black community exhibits a tendency to reject institutional care for the elderly. More value is placed on the experience and the status of aging relatives. Blacks are under-represented in nursing homes.
- Black family life and social networks are flexible in their organization (as opposed to disorganization).
- Black families are more likely to incorporate children into other-than-nuclear family groups than are Whites (McGoldrick, Giordano, & Pearce, 1996).

c. Attitudes toward authority figures (including counseling)

- They are most likely to respond positively to directive, active counselors who openly acknowledge the family strengths and avoid professional jargon (Hines, & Boyd-Franklin, 1996).
- Excessive compliance to the wishes of perceived authority figures may be identified with the African American's traditional powerlessness in the face of whites (Liggan, & Kay, 1999).
- "African Americans appear to have a central conflict between racial pride and an underlying image of self as inferior, primitive and 'nonwhite'" (Liggan, et al., 1999, p. 199).
- Anger towards the demands of mothers in matriarchal single parent homes is common, while the absent father role is generally not attributed blame (Liggan, et al., 1999).
- Black men claim to have been castrated by society, and that black women have avoided this persecution. The disproportionate rise of black women over black men in the middle class serves as the illustration for this paradigm.

d. Counseling Issues

- It is vital for counselors to be open to the extent to which a strong spiritual base is central to the resilience demonstrated by individuals.
- Counselors should work within the confines of a family's belief system rather than attempt to modify their beliefs. Those who are familiar with scriptural passages should cite biblical authority to support therapeutic recommendations (McGoldrick, 1998).
- Counselors need to consider the extended family evidenced as a multigenerational interdependent kinship system welded together by a sense of obligation within family members to each other.
- Presenting problems include psychosomatic difficulties, self esteem issues (especially in males), violence, and substance abuse.
- Therapeutic suggestions include concrete structured approaches, self-disclosure, inclusion of spirituality, and psychoeducation of social or vocational skills.

e. Acculturation

- In contrast to the European premise, “I think, therefore, I am,” the prevailing African philosophy is, “we are, therefore, I am.” In effect, individuals owed their existence to the tribe (McGoldrick, Giordano, & Pearce, 1996, p. 68).

f. Spirituality

- The church provides a support system, social activities, and a network of people who are available to the African American family in times of crisis (McGoldrick, 1998).
- Spirituality sustained the slaves during the times of servitude. When the native religions were forbidden, they adopted the religion of their captors. In some places, the African gods were blended with the Christian God and saints (McGoldrick, Giordano, & Pearce, 1996).

3. Hispanic Americans

a. Facts

- Hispanic refers to U.S. residents whose ethnic roots are in Mexico, Central America, South America, Puerto Rico, and Cuba.
- Thirty-two million eight-hundred thousand Hispanics make up 12 percent of the U.S. population (89.4% live in the West and the South) (U.S. Census Bureau, 2000).
- The Hispanic population is the largest U.S. minority group (U.S. Census Bureau, 2000)

b. Family structure

- *Machismo* and *marianismo* are constructs that tend to organize gender roles in their culture (McGoldrick, Giordano, & Pearce, 1996).
- Most Latinas are expected to live with their parents until they marry. They leave home only as brides dressed in white.
- Having children raises the status of women in society and is a rite of passage into adulthood. This rite confirms both the masculinity of the father and the femininity of the mother.
- Mutual aid in the extended family has been a cultural pattern that provides support and flexibility for women (McGoldrick, 1998).
- Men often consider their roles as leaders and providers for their families as their highest priority. Faced with unemployment, some will leave the family rather than face shame.
- Males are taught early that they are obligated to protect female siblings. Girls are expected to care for siblings, to clean house, to prepare food, etc. while the boys take on masculine chores outside of the house.
- Adult males have freedom of movement in the larger society, but women are expected to remain close to the home. A woman's support system contains her daughter and other female relatives.

c. Attitudes toward authority figures (including counseling)

- The Hispanic's respect for authority may keep him/her from speaking up and asserting his/her rights (McGoldrick, Giordano, & Pearce, 1996).
- It is both an obligation and a rite of passage defining womanhood to take care of old, poor, or frail parents or other relatives (McGoldrick, 1998).
- Health beliefs may include the use of folk healers (Curandero). Illness may be seen as punishment from God.
- In the traditional Chicano family, the aged were useful members of the family. This is difficult for aging Mexican Americans in the U.S. because the young have moved away and don't need their skills.

d. Counseling Issues

- Presenting problems include struggles of loyalty and disloyalty when transitioning away from the family, conflicting cultural demands of different generations, violence, teen pregnancy, and self esteem issues of women.
- Therapeutic suggestions include inclusion of family members in counseling, deference to father or male authority figures, and inclusion of rituals and metaphors.

e. Acculturation

- Hispanic or Latino are adjectives used to describe people who come from different countries with different cultures and sociopolitical histories, and who, in their countries of origin would never describe themselves in that way.
- Once in the U. S., poverty is a way of life for the majority of Latinos who live in this society. Their inability to access resources keeps them locked in a cycle that is oppressive and demoralizing.
- Latinos may experience similar injustices but compete among the different groups. Racism and classism influence relationships within and among the groups and contribute to a pecking order marked by prejudice and stereotypes (McGoldrick, Giordano, & Pearce, 1996).

f. Spirituality

- The majority of Hispanics (an estimated 90% of Mexican Americans along with other Hispanic groups) belong to the Roman Catholic Church.
- As a culture, there is an emphasis on spiritual values.
- Individuals and family systems are encouraged to sacrifice material satisfaction for spiritual goals.
- There is a reliance on Curanderos (folk healers) who coexist with religion and medical practices (Garcia-Preto, 1996)

4. Asian Americans

a. Facts

- According to the 2000 U.S. Census, the Asian-American population of the U.S. is composed of the following peoples: Chinese, Filipino, Japanese, Asian Indian, Korean, Vietnamese, Hawaiian, Samoan, Guamanian, Pakistani, Indonesian, and Fiji Islanders.
- Many Asians consider eye-to-eye contact shameful. This is especially true for women who may believe that only women with low morals make direct eye contact.
- Physical and verbal expressions of love are uncommon (McGoldrick, Giordano, & Pearce, 1996).

b. Family structure

- In traditional Asian families, the family unit – rather than the individual – is highly valued. The individual is seen as the product of all the generations of his or her family.
- An individual is expected to function in his or her clearly defined roles and within positions in the family hierarchy, based on age, gender, and social class.
- The dominant relationship is placed on the parent-child dyad, rather than the husband-wife dyad. The husband assumes the role of leadership and authority and is the provider and the protector of the family. The wife assumes the role of homemaker and childbearer.
- Divorce is rare. The wife is usually dominated by the authority of her husband, her father, her in-laws, and sometimes her son.
- The father and mother's functions tend to be complementary, rather than symmetrical.
- The strongest emotional attachment for a woman is sometimes not her husband but her children (especially her sons).
- Because of the large number of children in many Asian families, the parents usually delegate child-care functions to older siblings (especially the oldest daughter). Due to historical practices of sexism, sons are favored.
- During a crisis, Asian families can usually count on support from extended family members, friends, and ethnic community networks and organizations (McGoldrick, Giordano, & Pearce, 1996).

c. Attitudes toward authority figures (including counseling)

- The individuals' personal actions reflect not only on themselves but also on their extended family and ancestors.
- Parents expect to be cared for in their old age.

d. Counseling Issues

- Asian Americans may feel uncomfortable about expressing feelings or may be ashamed about needing help. Problem-solving techniques have been found to be more useful than feelings-based approaches.
- Asians are likely to express deference to others, to devalue self and family to others, and to avoid confrontation. They may view a counselor as an authority figure and be deferent.
- Asian Americans tend to believe that if something is wrong, the family is to blame. They under-utilize mental health services and often do not go to counselors unless there are major problems or psychosis.
- Presenting problems include conflict between generations due to various levels of acculturation, difficulty with acculturation, and struggles associated with socioeconomic level.
- Therapeutic suggestions include treating elders with respect, aiding in effective communication between parental and child subsystems, conflict resolution, and connection with community resources.

e. Acculturation

- Varying degrees of acculturation exist among the different groups.
- The rate of acculturation is strongly influenced by an immigrant's prior exposure to urbanization and Western culture.
- Immigrants who are less acculturated tend to hold on to traditional family values and gender roles.
- Many Asian American families are in transition from an extended family to a nuclear unit through the inevitable changes induced by migration, urbanization, and modernization.
- Most Asian countries have suffered years of war and political turmoil, the stress of which compounds the migration strain that all immigrants experience.

f. Spirituality

- In many Asian countries, religious organizations are highly respected. The priest, minister, or Buddhist monk is a key figure in the process of understanding and solving family problems (McGoldrick, Giordano, & Pearce, 1996).
- Asian Americans come from a variety of religious backgrounds, such as Christian, Buddhist, Shinto, or Muslim. Family behavior is influenced by religious beliefs (McGoldrick, 1998).

D. Discrimination and Stereotyping

The common thread running through the literature on minority groups is the problems they encounter due to **discrimination, stereotyping, and prejudice**. The **Minority Identity Development (MID)** model was developed by Atkinson, Morten, and Sue (1989) to help in revealing the possible psychological development patterns of minority group members. The following general stages are contained in the MID:

1. **Conformity** is characterized by a preference for the dominant culture. One's own group is depreciated; discrimination is exhibited toward other minorities.
2. **Dissonance** is characterized by cultural confusion and therefore conflict toward the dominant culture system. Conflict also exists between the dominant-held view toward other minorities and feelings of shared experience.
3. **Resistance and immersion** is characterized by active rejection of the dominant culture in conjunction with an intense desire to re-establish and to regain one's own primary ways and traditions.
4. **Introspection** is characterized by a questioning of the influence of the two cultures (the dominant and the minority) upon one's personal autonomous standing and development. Personal conflict may result.
5. **Synergetic articulation and awareness** is characterized by adopting a cultural identity that reconciles one's personal identity with an altruistic yet realistic knowledge and understanding of the minority-majority group relationship and issues.

The counselor must have the skills to recognize the psychological and the emotional needs of oppressed clients and counselors (both themselves and colleagues).

ADDITIONAL DEFINITIONS

1. **Acculturation** – ethnic groups responding to contact with the dominant culture by variously accepting, reformulating, or rejecting elements of the dominant culture.
2. **Ageism** – the discrimination of older persons.
3. **Assimilation** – the coming together of diverse ethnic and racial groups to share a common culture and to have equal access to opportunities; eventually, the groups become culturally indistinguishable from one another.
4. **Counterculture** refers to a group whose values place its members in opposition to the values of the broader culture.
5. **Culture** – the configuration of learned behavior and the results of behavior whose components and elements are shared and transmitted by the members of a particular society. It refers to customs, shared values, attitudes, and beliefs.
6. **Cultural awareness** refers to the awareness one has of one's own culture. It is measured by the Multicultural Awareness Continuum, a process of going through certain areas of awareness. These areas are (1) self awareness of one's own culture, (2) awareness of one's own culture, (3) awareness of racism, sexism, and poverty, (4) awareness of individual differences, (5) awareness of other cultures, (6) awareness of diversity, and (7) awareness of skills and techniques (Locke, 1993).
7. **Culture bound values** involve attitudes, beliefs, customs, and institutions identified as integral parts of a group's social structure.
8. **Culture epoch theory** says that education has to connect to the child's 'recapitulation' of the evolution of the human. In other words, education must be individualized and associated with the present level of understanding of the time.
9. **Cultural norm** – the expectations of how people are supposed to act. A culture is said to be normative in that it provides the individual with standards of conduct.
10. **Cultural pluralism** – By not surrendering their own culture entirely, subordinate groups form the basis for **cultural pluralism** through which diverse cultures coexist and maintain some degree of separate identity. They maintain their own cultural uniqueness while sharing common elements of the dominant American culture.
11. **Cultural relativism** is the understanding of a people from the framework of its own culture.
12. **Culture Shock** – The experience of losing all of one's familiar signs and symbols of social intercourse results in feelings of impotence, an inability to effectively deal with one's environment and to perform necessary role skills.
13. **Eclecticism** refers to employing the techniques from more than one theoretical orientation; selection is based on the particular problems presented by the individual client or patient.

14. **Empowerment** – the development of an effective support system for those who have been blocked from achieving individual or collective goals by the severity or complexity of the discrimination they have suffered.
15. **Ethnic Conflict** – the competition and conflict that increases as groups share a society resulting in ethnic stratification in which powerful ethnic groups limit the access of subordinate groups to wealth, power, and prestige.
16. **Ethnicity** refers to having distinctive cultural characteristics.
17. **Ethnocentrism** refers to using one's own culture as a yardstick for judging the ways of other individuals or societies, generally leading to a negative evaluation of their values, norms, and behaviors. The dominant culture is considered to be more important than the minority group cultures.
18. **Ideal culture** refers to the ideal values and norms of a people; the goals held out for them.
19. **Macroculture** – the dominant culture of a society in which the values, attitudes, and beliefs are esteemed within that particular society.
20. **Material culture** refers to the material objects that distinguish a group of people, such as their art, buildings, weapons, utensils, machines, hairstyles, clothing, and jewelry.
21. **Minority** – a group of people who, because of physical or cultural characteristics, are singled out from the others in the society in which they live for differential and unequal treatment, and who, therefore, regard themselves as objects of collective discrimination. The group usually includes a special factor, that of being oppressed in some way by a dominant cultural group.
22. **Modal personality** – the most common personality type within a society. There are typically a range of normal personality types within a society.
23. **Powerlessness** – a group's inability to use resources to achieve collective goals. Powerlessness need not result from lack of motivation or low self-esteem but is often the result of blocked funding or sanctions, institutionalized forms of disenfranchisement.
24. **Prejudice** refers to an irrational attitude directed toward an individual or a group or their supposed characteristics.
25. **Proxemics** – the study of a person's perception and use of personal and interpersonal space. Along with kinetics and paralanguage, it is an aspect of nonverbal behavior and is culturally conditioned.
26. **Race** refers to inherited physical characteristics that distinguish one group from another.
27. **Racism** is prejudice and discrimination on the basis of race.

- 28. **Semantic Differential** – a direct method of attitude measurement in which one assesses the connotative or personal meaning of an object.
- 29. **Social Facilitation** – the effects of individual performance on the presence of other individuals.
- 30. **Third cultures** – refer to financial markets, international law, and other elements that transcend national culture.
- 31. **Universal culture** – The human race is characterized by an underlying universal culture system. Clark Wissler has developed the universal culture concept, pointing out how every race has a type of family life, a type of government, a type of religion, and so on. This universal culture theory is supported psychologically, for the members of all human groups are characterized by a similar “inhibition of impulses, power of attention, and power of original thought.”

Chapter 14

References

Reference List

- Adler, A. (1963). The individual psychology of Alfred Adler: A systematic presentation in selections from his writings. New York: Harper & Row.
- Adler, A. (1958). What life should mean to you. New York: Capricorn.
- Aguilera, Donna C. Crisis Intervention: Theory and Methodology (8th ed.). St. Louis: 1998:1. Mosby.
- Allport, G. W. (1965). The person in psychology. Boston: Beacon Press.
- American Counseling Association (1995). Code of ethics and standard of practice. Alexandria, VA: Author.
- American Counseling Association <http://www.counseling.org/>
- American Psychiatric Association (1980). Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, DC.
- American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC.
- Aronson, E. (1986, August). Teaching Students Things They Think They Already Know About: The Case of Prejudice and Desegregation. Paper presented at the meeting of the American Psychological Association, Washington, D. C. In Kail and Cavanaugh Human Development.
- Aronson, M.L. (1990). "A group therapist's perspectives on the use of supervisory groups in the training of psychotherapists." Psychoanalysis and Psychotherapy, 8, 88-94.
- Association for Counseling Education and Supervision (1993). ACES Ethical Guidelines for Counseling Supervisors. www.acesonline.net/ethicalguidelines.htm
- Association for Specialists in Group Work, (1998) Best Practice Guidelines for Group Workers. <http://asgw.educ.kent.edu/>
- Association for Specialists in Group Work, (1998) Principles for Diversity-Competent Group Workers. <http://www.asgw.educ.kent.edu/>
- Association for Specialists in Group Work, (2000) Professional Standards for the Training of Group Workers. <http://asgw.educ.kent.edu/>
- Association for Women in Psychology (2002). www.awpsych.org
- Astin (1984). "The meaning of work in women's lives: A sociopsychological model of career choice and work behavior." The Counseling Psychologists, 12(4), 117-126. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th Ed. New York: Longman 265.
- Atkinson, D. R., Morten, G., Sue, D. W. (1983). Counseling American Minorities: A Cross-Cultural Perspective 2nd Ed, Dubuque, IA, William C. Brown.
- Austin, K. M., Moline, M. E., & Williams, G. T. (1990). Confronting Malpractice: Legal and Ethical Dilemmas in Psychotherapy. Newbury Park, CA, Sage Publications.
- Austin, Leonard (1999). The Counseling Primer. Philadelphia, PA: Brunner-Routledge.
- Axelson, J. (1993). Counseling and Development in a Multicultural Society 2nd Ed. Pacific Grove, CA, Brooks/Cole.
- Axelson, J. (1985). Counseling and Development in a Multicultural Society, Monterey, CA, Brooks/Cole.
- Axelson, John A. (1993). Counseling and Development in a Multicultural Society, 2nd Edition. Pacific Grove CA : Brooks/Cole Publishing Company.
- Axelson, John A. (1999). Counseling and Development in a Multicultural Society, 3rd Edition. Pacific Grove CA : Brooks/Cole Publishing Company.
- Azrin, N. H., & Besalel, V. A (1980). Job Club Counselor's Manual: A Behavioral Approach to Vocational Counseling. Baltimore: University Park Press
- in Sharf, R. S., (2002). Applying Career Development Theory to Counseling. Pacific Grove, CA: Brooks/Cole Publishing Company.
- Baltes, P. B. (1987). "Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline." Developmental Psychology, 23, 611-626.
- Bandler, R. and Grinder, J. (1979). Frogs into Princes: Neurolinguistic Programming. Moab, Utah: Real People Press.
- Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. (1982). "The psychology of chance encounters and life paths." The American Psychologist, 37(7), 747-755.
- Bandura, A. (1986). "Social foundations of thought and action: A social cognitive theory." Englewood Cliffs, NJ: Prentice-Hall. In Peterson, N. & Gonzalez, R. C. (2000). The role of work in people's lives: Applied career counseling and vocational psychology. Pacific Grove, CA: Brooks/Cole 325-354.
- Bandura, A. (1986). "Social foundations of thought and action: A social cognitive theory." Englewood Cliffs, NJ: Prentice-Hall. In Sharf, R. S., (1997). Applying Career Development Theory to Counseling. Pacific Grove, CA: Brooks/Cole Publishing Company 349.
- Baumrind, D. (1971). "Current patterns of parental authority." Developmental Psychology Monographs, 4 (1,Pt. 2). In Kail and Cavanaugh Human Development.
- Beavers, W.R. (1985). Successful marriage: A family systems approach to couples therapy. New York: Norton.
- Beck, A. T. (1976). Cognitive therapy and emotional disorders. New York: International Universities Press.
- Beck, A. T. and Haaga, D. A. F. (1992). "The Future of Cognitive Therapy." Psychotherapy, 29(1), 34-38.
- Beck, A. T. and Weishaar, M. E. (1995). In R. J. Corsini and D. Wedding (Eds.), Current psychotherapies (5th ed., pp. 229-261). Itasca, IL: F. E. Peacock.
- Beck, A.T. (1988). Love Is Never Enough. NY: Harper & Row.
- Becker, G. (1964). Human Capital. New York: Columbia University Press. In Sharf, R. S., (1997). Applying Career Development Theory to Counseling. Pacific Grove, CA: Brooks/Cole Publishing Company.
- Becvar, D. S. & Becvar R.J. (1996). Family Therapy: A systemic integration (3rd Ed.). Needham Heights, MA: Allyn and Bacon.
- Bee, H. L., & Mitchell, S. K. (1984). The Developing Person: A Lifespan Approach 2nd Ed. New York, NY, Harper & Row.
- Beer, Michael & Spector, Bert (1993). Organizational diagnosis: its role in organizational learning. Journal of Counseling and Development, 71, 642-650.
- Belkin, G.S. (1987). Contemporary Psychotherapies. Pacific Grove, CA: Brooks/Cole Publishing, 2nd ed.
- Bem, S. L. (1981). "Gender schema Theory: A cognitive account of sex typing." Psychological Review, 88, 354-364.
- Bem, S. L. (1993). The Lenses of Gender. New Haven, CT: Yale University Press.
- Bem, S. L. (1975). "Androgyne vs. the Tight Little Lives of Fluffy Women and Chesty Men." Psychology Today.
- Benin, M. H. and Agostinelli, J. (1988). "Husbands' and Wives' Satisfaction with the Division of Labor." Journal of Marriage and the Family 50 May: 349-361. In Janeen Baxter and Mark Western (1996). Satisfaction with Housework: Explaining the Paradox [On-line]. Available: <http://www.aifs.org.au/institute/afrcpapers/baxter.html>
- Bergland, B. W. (1974). "Career planning: The use of sequential evaluated experience." In E. L. Herr (Ed.) Vocational guidance and human development. Boston: Houghton Mifflin. In E. L. Herr and S. H. Cramer (1996). Career guidance and counseling through the lifespan (5th ed.) New York: Harper Collins Publishers, Inc..
- Berkowitz, L. (1969). Roots of aggression: A re-examination of the frustration-aggression hypothesis. New York: Atherton.
- Bernard, Janine M. and Goodyear, Rodney K. (1998). Fundamentals of clinical supervision 2nd ed. Boston: Allyn and Bacon.
- Berne, E. (1981) What Do You Say After You Say Hello? New York: Bantam Books.
- Berne, E. (1964) Games People Play. New York, NY, Grove Press.
- Bidwell, L. D. M., & Vander Mey, B. J. (2000). Sociology of the family: Investigating family issues. Boston: Allyn and Bacon.
- Biederman, J., Semrud-Clikeman, M., Sprich-Buckminster, S., Lehman, B. K., Faraone, S. V., & Norman, D. (1992). "Comorbidity between ADHD and learning disability: A review and report in a clinically referred sample." Journal of the American Academy of Child and Adolescent Psychiatry, 31, 439-448.
- Binder, J.L. and Strupp, H.H. (1997). "Supervision of psychodynamic therapies." In C.E. Watkins, Jr. (Ed.), Handbook of psychotherapy supervision. New York: Wiley.
- Bird, G. W., Bird, G. A., & Scruggs, M. (1984). "Determinants of family task sharing: A study of husbands and wives." Journal of Marriage and the Family, 46(2), 345-355. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman.

- Blashfield, R. K. & Draguns, J. G. (1976). "Evaluative criteria for psychiatric classification." *Journal of Abnormal Psychology*, 85, 140-150.
- Bogardus, E. S. (1945). *Sociology (revised Ed.)*. New York: McMillan.
- Borders, L.D. and Leddick, G.R. (1987). *Handbook of counseling supervision*. Alexandria, VA: American Association for Counseling and Development.
- Borders, L.D., Fong, M.L., and Neimeyer, G.J., (1986) Counseling students' level of ego development and perceptions of clients. *Counselor Education and Supervision*. Vol. 26, pp. 36-49, cited in Bernard and Goodyear (1998).
- Bordin, E. S., (1984). Psychodynamic Model of Career Choice and Satisfaction. In D. Brown & L. Brooks (Eds.), *Career Choice and Development: Applying Contemporary Theories To Practice* (Chap. 5). San Francisco: Jossey-Bass in Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman.
- Bordin, E. S., Nachmann, B., & Segal, S. J. (1963). An articulated framework for vocational development. *Journal of Counseling Psychology*, 10, 107-116 in Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 212-213.
- Bradley, Loretta J. and Ladany, Nicholas, eds. (2001). *Counselor supervision*. Philadelphia: Brunner-Routledge.
- Brill A. A. (1948). *Psychoanalytic Psychiatry*. London: John Lehman in Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman.
- Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosenkrantz, P., & Vogel, S. R. (1970). "Sex-role -stereotypes and clinical judgments of mental health." *Journal of Consulting and Clinical Psychology*, 34, 1-7.
- Brown, D. (1993). "Training Consultants: A Call to Action." *Journal of Counseling and Development*, 72, 139-143.
- Brown, D. (1996). Brown's values-based, holistic model of career and life-role choices and satisfaction. In D. Brown & L. Brooks (Eds.) *Career choice and development* (3rd ed.) San Francisco: Jossey-Bass 337-372. In Patton, W. & McMahon, M. (1999). *Career development and systems theory: A new relationship*. Pacific Grove, CA: Brooks/Cole 28-30.
- Bugental, J.F.T. (1977). *The Art of the Psychotherapist: Keys to the Subtle Skills of Master Therapists*. NY: W.W. Norton & Co.
- Burnstein, E. (1963). "Fear of failure, achievement motivation, and aspiring to prestigious occupations." *Journal of Abnormal and Social Psychology*, 67, 189-193. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman.
- Buros, O. (1961). *Tests in Print*, Univ of Nebraska PR.
- Buros, O. (1985). *The Tenth Mental Measurement Yearbook*, Highland Park, IL, Gryphon.
- Cabral, A. C., & Salamone, P. R. (1990). "Chance and careers: Normative versus contextual development." *Career Development Quarterly*, 39(1), 5-17.
- Caplan, G. & Caplan, R. B. (1999). *Mental health consultation and collaboration*. Prospect Heights, IL: Waveland Press.
- Caplan, G. (1970). *Theory and Practice of Mental Health Consultation*. New York: Basic Books.
- Carkhuff, R. R. & Berenson, B. G. (1977). *Beyond counseling and therapy (2nd Ed.)* New York: Holt, Rinehart & Wilson. p. 194.
- Carkhuff, R. R. (1969). *Helping and human relations: a primer for lay and professional helpers*. New York: Holt, Rinehart and Winston.
- Carkhuff, R. R. (1981). *Toward actualizing human potential*. Amherst, MA: Human Resource Development Press.
- Carkhuff, R.R., & Berenson, B.C. (1977). *Beyond Counseling and Therapy*. NY: Rinehart & Winston.
- Carter, B. & McGoldrick, M. (1999). *The Expanded Family Life Cycle (3rd Ed.)*. Boston: Allyn and Bacon.
- Case, R. (1985). *Intellectual development: Birth to adulthood*. New York: Academic Press.
- Cattell, R. B. (1946). *Description and measurement of personality*. New York: Harcourt.
- Chartrand, J.M. (1991). The Evolution of trait-and-factor career counseling: A Person X Environment fit approach. *Journal of Counseling and Development*, 69, 518-524 in Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 180-181.
- Chesler, P. (1972). *Women and madness*. New York: Doubleday.
- Chickering, A. (1987). *Education and identity*. San Francisco, CA: Jossey-Bass.
- Chodorow, N. J. (1989). *Feminism and psychoanalytic theory*. New Haven, CT: Yale University Press.
- Chodorow, N. J. (1978). *The reproduction of mothering*. Berkeley: University of California Press.
- Combs, Arthur W. and Gonzalez, David M. (1994). *Helping Relationships: Basic Concepts for the Helping Professions*. Needham Heights, MA: Allyn and Bacon.
- Cooper, Stewart E. & O'Connor, Raymond M (1993). "Standards for organizational consultation assessment and evaluation." *Journal of Counseling and Development*, 71, 651-660.
- Coopersmith, S. (1967). *The antecedents of self-esteem*. San Francisco: W. H. Freeman.
- Corey, G. and Schneider, M. (1977). *Groups: Process and Practice*. Monterey, CA, Brooks/Cole.
- Corey, Gerald, Corey, Marianne Schneider, and Callanan, Patrick (1998). *Issues and Ethics in the Helping Professions 5th ed.* Pacific Grove, CA.: Brooks/Cole Publishing.
- Corey, Gerald, et al. (2003). *Issues & Ethics in the Helping Professions 6th ed.* Pacific Grove: Brooks/Cole.
- Corey, Gerald (2001). *Case Approach to Counseling and Psychotherapy*. Stamford, CT: Wadsworth.
- Corey, Gerald (2001). *The Art of Integrative Counseling*. Belmont CA: Brooks/Cole Thomson Learning.
- Corey, Gerald (1985). *Theory & Practice of Group Counseling 2nd Ed.* Monterey, CA: Brooks/Cole.
- Corey, Gerald (1995). *Theory & Practice of Group Counseling 4th Ed.* Pacific Grove, CA: Brooks/Cole.
- Corey, Gerald (2000). *Theory & Practice of Group Counseling 5th Ed.* Stamford: Wadsworth.
- Corey, Gerald (1986). *Theory and Practice of Counseling and Psychotherapy 3rd Ed.* Monterey, CA : Brooks/Cole.
- Corey, Gerald (1996). *Theory and Practice of Counseling and Psychotherapy 5th Ed.* Pacific Grove CA: Brooks/Cole.
- Corey, Gerald (2000). *Theory and Practice of Counseling and Psychotherapy 6th Edition*. Pacific Grove: Brooks/Cole.
- Corey, Gerald; Corey, Marianne Schneider; Callanan, Patrick; and Russell, J. Michael (1992). *Group Techniques*. Pacific Grove CA: Brooks/Cole.
- Corimer, L.S. & Hackney, H. (1987). *The professional counselor: A process guide to helping*. Upper Saddle River, NJ: Prentice Hall.
- Cormier, W.H., & Cormier, L.S. (1991). *Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interactions*. Pacific Grove, CA: Brooks/Cole.
- Cornell School of Law Legal Information Institute. Discrimination (2002). [on-line] Available: http://www.law.cornell.edu/topics/employment_discrimination.html.
- Corsini, Raymond J., Editor (1984). *Encyclopedia of Psychology*. New York: John Wiley & Sons, Inc.
- Crites, J. O. (1969). Vocational psychology. New York: McGraw-Hill. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 615.
- Cronback, L. (1984). *Essentials of Psychological Testing*. New York, Harper and Row.
- Dacey, J. and Travers, J. (1994). *Human Development Across the Lifespan*. Dubuque, IA: Brown and Benchmark.
- Dattilio, F. M., & Freeman, A. (Eds.). (1992). *Introduction to cognitive therapy*. In A. Freeman & E. M. Dattilio (Eds.), *Comprehensive casebook of cognitive therapy* (pp. 3-11). New York: Guilford Press.
- Dawis, R. V. (1994) The Theory of Work Adjustment As Convergent Theory. In M. L. Savickas & R. W. Lent Dawis (Eds.), *Convergence in career development theories* (pp. 33-44). Palo Alto, CA: Consulting Psychologists Press in Sharf, R. S., (2002). *Applying Career Development Theory to Counseling*. Pacific Grove, CA: Brooks/Cole Publishing Company.
- Dixon, David N. 7 Dixon, Diane E. (1993). Research in consultation: toward better analogues and outcome measures. *Journal of Counseling and Development*, 71, 700-702.
- Doerhman, M. (1976). "Parallel processes in supervision and psychotherapy." *Bulletin of the Menninger Clinic*, 40, 3-104.
- Dollard, J. and Miller, N. E. *Personality and Psychotherapy: An Analysis in Terms of Learning, Thinking, and Culture*. New York: McGraw-Hill 1950.

- Dollard, J., Miller, N.E., Doob, L.W., Mowrer, O.H., & Sears, R.R. (1939). *Frustration and aggression*. London: Oxford University Press.
- Dougherty, A.M. (2000). *Psychological Consultation and Collaboration* (3rd ed.). Pacific Grove, CA: Brooks/Cole.
- Duncan, K. C., Prus, M. J., & Sandy, J. G. (1993). Marital status, children and women's labor market choices. *Journal of Socio-Economics*, 22, 277-288.
- In Sharf, R. S., (1997). *Applying Career Development Theory to Counseling*. Pacific Grove, CA: Brooks/Cole Publishing Company, 408.
- Egan, Gerard. *The Skilled Helper: A Problem Management Approach to Helping* 6th Edition Pacific Grove CA: Brooks/Cole Publishing Company 1998.
- Ekstein, R. & Wallerstein, R.S. (1972). *The teaching and learning of psychotherapy* (2nd ed.). New York: International Universities Press.
- Elkind, D. (1976). *Child development and education: A Piagetian perspective*. New York: Oxford University Press.
- Elkind, D. (January, 1988). Educating the very young: A call for clear thinking. *NEA Today*, pp.22-27.
- Ellis, A. *Humanistic Psychotherapy: The Rational-Emotive Approach*. New York: Julian Press 1973.
- Ellis, A. *Reason and Emotion in Psychotherapy*. New York: Stuart 1962.
- Ellis, A. and Harper, R. *A Guide to rational Living* 3rd Edition. North Hollywood, CA: Wilshire 1997.
- Enns, C. Z. Twenty years of feminist counseling and therapy: From naming biases to implementing multifaceted practice. *The Counseling Psychologist*, 21(1), 3-87. 1993.
- Erikson, E. H. (1950, 1963) *Childhood and Society*, New York: W. W. Norton.
- Erikson, E. H. *Childhood and Society* 2nd Ed. New York, NY, Norton, 1963.
- Faiver, Christopher; Ingersoll, R. Elliott; O'Brien, Eugene; and McNally, Christopher. *Explorations in Counseling and Spirituality*. Stamford, CT: Wadsworth, 2001.
- Fehr, Scott Simon. *Introduction to Group Therapy*. New York: The Haworth Press 1999.
- Fine, M., & Asch, A. (1988) Disability beyond stigma: Social interactions, discrimination, and activism. *Journal of Social Issues*, 44(1) 3-21. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 294.
- Flavell, J. H. (1992). Cognitive development: Past, present, and future. *Developmental Psychology*, 28, 998-1005.
- Fogiel, M. *The Psychology Problem Solver*. Piscataway, NJ: Research and Education Association 1980.
- Fong, Margaret L. and Lease, Suzanne H. (1997). "Cross-Cultural supervision: Issues for the white supervisor." In Pope-Davis and Coleman (1997), *Multicultural Counseling Competencies*.
- Ford, Gary George (2001). *Ethical Reasoning in the Mental Health Professions*. Boca Raton: CRC Press.
- Garcia-Preto, N. (1996). Latino families: An overview. In M. McGoldrick, J. Giordan, & J.K. Pearce. (Eds.). *Ethnicity and family therapy*. New York: Guilford.
- Garrett, J., & Garrett, M. (1994). The path of good medicine: Understanding and counseling Native American Indians. *Journal of Multicultural Counseling & Development*, vol. 22.
- Gazda, G., Asburg, F., Balzer, F., Childers, W., & Walters, R.P. (1999). *Human relations development: A manual for educators* (5h Ed.). Boston, Allyn & Bacon, Inc.
- Gazda, George M.; Ginter, Earl J.; and Horne, Arthur M. *Group Counseling and Group Psychotherapy* Needham Heights, MA: Allyn & Bacon 2001.
- Gelatt, H. B. (1962). Decision-making. A conceptual frame of reference for counseling. *Journal of Counseling Psychology*, 9, 240-245. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman. 190-191.
- Gelatt, H. B., (1991). Creative decision-making: Using positive uncertainty. San Jose, CA: Crisp Publications. In Peterson, N. & Gonzalez, R. C. (2000). *The role of work in people's lives: Applied career counseling and vocational psychology*. Pacific Grove, CA: Brooks/Cole 218-219.
- Gilligan, C. The centrality of relationships in human development. In *Development & vulnerability in close relationships* edited by G. G. Noam and K. W. Fischer. Mahway, NJ: Lawrence Erlbaum 1996.
- Gilligan, C. and Brown, L. M. *Meeting at the Crossroads: women's and Girls' Development* Cambridge, MA: Harvard University Press 1992.
- Gilligan, Carol (1985, March). Remapping development. Paper presented at the biennial meeting of the Society for Research in Child Development, Toronto. Referenced in Kail and Cavanaugh, *Human Development*.
- Gilligan, Carol. (1982). *In a Different Voice*. Harvard Univ Pr.
- Gilligan, Carol. *In a Different Voice: Psychological Theory and Women's Development* Cambridge MA: Harvard University Press 1982.
- Ginzberg, E., Ginsburg, S. W., Axelrad, S., & Herma, J. (1951). Occupational choice: An approach to a general theory. New York: Columbia University Press. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 228-229.
- Glasser, N. (Ed.) What are you doing? How people are helped through reality therapy New York: Harper and Row 1980.
- Glasser, W. *Reality Therapy: A New Approach to Psychiatry* New York: Harper and Row 1965.
- Glasser, W. *Reality Therapy: An Explanation of the steps of reality therapy*. In N. Glasser (Ed.), *What are you doing? How people are helped through reality therapy* (pp. 48-60) New York: Harper and Row 1980.
- Goldenberg, I., & Goldenberg, H. (2000). *Family Therapy: An overview. (5th edition)*. Belmont, CA: Wadsworth/Thomson Learning.
- Goodlad, J. I (1983). *A place called school: Prospects for the future*. New York: McGraw-Hill.
- Goodyear, R.K and Sinnett, E.D. (1984). "Current and emerging ethical issues for counseling psychologists." *Counseling Psychologists*, 12(3), 87-98.
- Gottfredson, L. S. (1981). Circumscription and compromise: A developmental theory of occupational aspirations. *Journal of Counseling Psychology*, 28(6), 545-579. In Herr, E.L. & Cramer, S. H. (1996).
- Gould, R. L. (1978). Transformations: Growth and change in adult life. New York: Simon & Schuster. Harlow, H. F. & Zimmerman, R. R. (1959). Affectional responses in the infant monkey. *Science*, 130, 431-432.
- Griffith, B. A., & Rotter, J. C. (1999). Families and spirituality: Therapists as facilitators. *The Family Journal: Counseling and therapy for couples and families*, 7(2), 161-164.
- Gurman, A. S., & Kniskern, D.P. (Eds.) (1981). *Handbook of family therapy*. New York: Brunner/Mazel.
- Guthrie, E. R. (1952). *The psychology of learning*. New York: Harper.
- Hackett, G. & Betz N.E., (1981). A self-efficacy approach to the career development of women. *Journal of Vocational Behavior*, 18, 326-339. In Patton, W. & McMahon, M. (1999). *Career development and systems theory: A new relationship*. Pacific Grove, CA: Brooks/Cole, 99.
- Hackney, H.L., Goodyear, R.K. (1984). Carl Rogers' client-centered supervision. In R.F. Levant and J.M Schlien (Eds.) *Client-centered therapy and the person-centered approach*. New York: Praeger.
- Haley, Jay (1987). *Problem-Solving Therapy*. 2nd ed. San Francisco: Jossey-Bass.
- Harris, Thomas. *I'm OK – You're OK*. New York: Harper and Row 1995.
- Havighurst, R. J. (1951). *Developmental tasks and education* (2nd ed.) New York: Longman.
- Hedges, L. E. (1983). *Listening perspectives in psychotherapy*. New York: Aronson.
- Heider, F. (1958). *The psychology of interpersonal relations*. Hillsdale, NJ: Erlbaum.
- Henslin, J. M. (1997). *Sociology: A down-to-earth approach. (3rd Ed.)*. Boston, MA: Allyn and Bacon.
- Herr, E. L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 244-245.
- Herr, E. L., (1982). Career development and vocational guidance. In H. F. Silberman (Ed.), *Education and work*. Chicago: University of Chicago Press. 21-22. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 299-300.
- Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman, 189.
- Hill, R. C. *The Strength of Black Families*, New York, NY, Emerson Hall, 1972.
- Hines, P., & Boyd-Franklin, N. (1996). African American families. In M. McGoldrick, J. Giordano, & J. Pearce (Eds.), *Ethnicity & Family Therapy*, 2nd edition (pp. 66-84). New York: Guilford Press.
- Hock, Roger R. *Forty Studies That Changed Psychology*. Upper Saddle River NJ: Prentice Hall 1999.

- Holloway, E.L. (1995). *Clinical Supervision: A systems approach*. Thousand Oaks, CA: Sage.
- Hoppock, R. (1976). *Occupational Information*. New York: McGraw-Hill. In Peterson, G. W., Sampson, J. P., Jr., & Reardon, R. C. (1991). *Career Development and Services: A cognitive approach*. Pacific Grove, CA: Brooks/Cole 15.
- Horney, Karen. *Feminine Psychology*. New York: W. W. Norton 1967.
- Hotchkiss, L., & Borrow, H. (1990). *Sociological Perspectives On Work and Career Development*. In D. Brown and L Brooks (eds.) *Career Choice and Development. Applying Contemporary Theories To Practice* (262-307). San Francisco: Jossey-Bass. In Sharf, R. S., (1997). *Applying Career Development Theory to Counseling*. Pacific Grove, CA: Brooks/Cole Publishing Company 405.
- Hunt, M. *The History of Psychology*. New York: Doubleday 1993.
- Ibrahim, F.A. (1991). Contribution of cultural world view to generic counseling and development. *Journal of Counseling and Development*, 70, 13-19.
- Ivey, A. E. and Authier, J. (1978). *Microcounseling* (2nd ed.). Springfield, IL: Charles C. Thomas.
- Ivey, A. E. and Ivey, M. B. (1999). *Intentional interviewing and counseling* (4th ed.). Pacific Grove, CA: Brooks/Cole.
- Jackson, Dennis N., & Hayes, Denise Hughley (1993). Multicultural issues in consultation. *Journal of Counseling and Development*, 72, 144-147.
- Jacobi, Joland. *Complex/Sarchetype/Symbol in the Psychology of C. G. Jung*. Translated from the German by Ralph Manheim. New York: Princeton University Press 1959.
- Jacobson, E. *Progressive Relaxation*. Chicago: University of Chicago Press 1974.
- James, Richard.; Gilliland, Burel. (2001). *Crisis Intervention Strategies, 4th Edition*. Pacific Grove. CA: Brooks/Cole pp. 31-34.
- Janis, I. & Mann, L. (1977). *Decision-making: A psychological analysis of conflict, choice, and commitment*. New York: The Free Press. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed*. New York: Longman 609.
- Jones, W. (1968). "The A-B-C method of crisis management. *Mental Hygiene* 52, pp. 87-89.
- Jung, C. G. *Memories, Dreams, Reflections*. New York: Vintage 1961.
- Kail, Robert V and Cavanaugh, John C. *Human Development: A Lifespan View* 2nd Edition Belmont CA: Wadsworth Thomson Learning 2000.
- Kanel, Kristi. 2003. *A Guide to Crisis Intervention, Second Edition*. Pacific Grove. CA: Brooks/Cole.
- Kegan, R. (1982). *The Evolving Self: Problem and Process in human development*. Cambridge: Harvard University Press.
- Kelly, G. A. *The Psychology of Personal Constructs*. New York: Norton 1955.
- Key, W. B. *Media Sexploitation*. New York: Prentice Hall 1976.
- Key, W. B. *Subliminal Seduction: Ad Media's Manipulation of a Not So Innocent America* New York: Prentice Hall 1973.
- Kiselica, M.S. (1998). "Preparing Anglos for the challenges and joys of multiculturalism." *The Counseling Psychologist*, 26, 5-21.
- Klein, Melanie. *Love, Guilt and Reparation and other works 1921-1945* London, England: Vintage/Random House 1998.
- Knowles, M. & Knowles, H. *Introduction to Group Dynamics*. New York, NY: Association Press, 1959.
- Kohler, W. *The mentality of Apes*. New York: Liveright 1925.
- Kottler, Jeffrey A. *Advanced Group Leadership*. Pacific Grove CA: Brooks/Cole Publishing Company 1994.
- Krumboltz, J. D. (1983) *Private Rules In Career Decision Making*. Columbus, OH: The National Center for Research in Vocational Education in Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed*. New York: Longman 199.
- Krumboltz, J. D. (1983). *The identification of troublesome private rules in career decision making*. Columbus: Advance Study Center, National Center for Research in Vocational Education, Ohio State University.
- Krumboltz, J. D., Mitchell, A., & Gelatt, H. G. (1975). Applications of social learning theory of career selection. *Focus on Guidance*, 8, 1-16.
- Krumboltz, J.D. (1994). The Career Beliefs Inventory. *Journal of Counseling and Development*, 72, in Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed*. New York: Longman 197-198.
- Kubler-Ross, E. *On Death and Dying*. New York, NY, Macmillan, 1969.
- Kuh, G. & Hall, J. (1993). "Using Cultural perspective in student affairs." *Cultural Perspectives in Student Affairs Work*, 1-20. Laham, MD: ACPAIUP of America.
- Kurpius, DeWayne J., Fuqua, Dale R., Rozecki, Thaddeus (1993). The consulting process: a multidimensional approach. *Journal of Counseling and Development*, 71, 601-606.
- Lamanna, M. A., & Riedmann, A. (1997). *Marriages and families: Making choices in a diverse society* (6th Ed.). New York: Wadsworth.
- Lazarus, A. A. (1993). Tailoring the therapeutic relationship, or being an authentic chameleon. *Psychotherapy*, 30, 404-407.
- Lazarus, A. A. *Behavior Therapy and Beyond*. New York: McGraw-Hill 1971.
- Lazarus, A. A. *Brief but comprehensive psychotherapy: The multimodal way*. New York: Springer 1997.
- Lazarus, A.A., *Casebook of Multimodal Therapy*. NY: Guilford Press, 1985.
- Lent, R.W., Brown, S. D., and Hackett, G. (1996). Career development from a social cognitive perspective. In D. Brown, L. Brooks, and Associates (Eds.), *Career choice and development* (3rd edition). San Francisco: Jossey-Bass 373-421. In Peterson, N. & Gonzalez, R. C. (2000). The role of work in people's lives: Applied career counseling and vocational psychology. Pacific Grove, CA: Brooks/Cole 217.
- Levinson, D. J. (1978). *Seasons of a man's life*. New York: Alfred A. Knopf.
- Levinson, D. J. (1978). *The season's of a woman's life*. New York: Knopf.
- Lewis, J. & Bradley, L. (2000). *Advocacy in counseling: Counselors, clients, & community*. Greensboro, N.C.: ACA and ERIC/CASS, 172.
- Liggan, D. & Kay, J. (1999). Race in the room: Issues in the dynamic psychotherapy of African Americans. *Transcultural Psychiatry*, vol. 36, 195-210.
- Lindemann E. (1944). *Symptomatology and management of acute grief*. American Journal of Psychiatry. 101:101.
- Lippitt, R. & Lippitt, G. (1978). *The consulting process in action*. La Jolla, CA: University Associates.
- Lipsett, L. (1962). Social factors in vocational development. *Personnel and Guidance Journal*, 40,432-437. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed*. New York: Longman 209-210.
- Locke, E.C. (1993). Multicultural counseling. *ERIC Digest*. Ann Arbor, MI: Clearinghouse on Counseling and Personnel Services.
- Loevinger, J. (1976). *Ego development: Conceptions and theories*. San Francisco: Jossey-Bass.
- Lorenz, K. Z. (1965). *Evolution and modification of behavior*. Chicago: University of Chicago Press.
- Luft, Joseph (1969). "Of Human Interaction," Palo Alto, CA: National Press.
- Maccoby, M., & Terzi, K. (1981). What happened to the work ethic? In J. O'Toole, J. L. Scheiber, & L. C. Wood (Eds.), *Working, changes and choices*. New York: Human Sciences Press. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed*. New York: Longman 76.
- Mahone, C. H. (1960). Fear of failure and unrealistic vocational aspiration. *Journal of Abnormal and Social Psychology*. 60, 253-261. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed*. New York: Longman 184.
- Marino, T. W. (1995). "Crisis counseling: Helping normal people cope with abnormal situations. *Counseling Today*, 38(3), 25.
- Maslow, A. *Toward a Psychology of Being* New York: Van Nostrand Reinhold 1962.
- Masters, W. H. and Johnson, V. E. *Human Sexual Response*. Boston: Little, Brown, 1966.
- Maultsby, M. C. *Rational Behavior Therapy*. Englewood Cliffs, NJ: Prentice-Hall 1984.
- McGoldrick, M. (Ed.) (1998). *Re-Visioning Family Therapy: Race, culture, and gender in clinical practice*. New York: Guilford.
- McGoldrick, M., Giordano, J., & Pearce, J.K. (Eds.). (1996). *Ethnicity and family therapy* (2nd Ed.). New York: Guilford.
- Meara, N.M. et al. (1996). "Principles and Virtues: A Foundation for Ethical Decisions, Policies, and Character." *Counseling Psychologist*, 24, 4-77.
- Meichenbaum, D. *Cognitive Behavior Modification: An Integrative Approach*. New York: Plenum 1977.
- Meichenbaum, D. *Stress Inoculation Training*. New York: Pergamon Press 1985.

- Meltzoff, A. N. (1990, June). Infant imitation. Invited address at the University of Texas at Dallas, School of Human Development and Communication Sciences Richardson, TX.
- Miller, A. L., & Tiedeman, D. V., (1972). Decision making for the 70's: The cubing of the Tiedeman paradigm and its application in career education. *Focus on Guidance*, 5(1) 1-15. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman. 242.
- Miller, A. L., & Tiedeman, D. V., (1977) Structuring responsibility in adolescents actualizing "I" power through curriculum. In G. D. Miller (Ed.), *Developmental theory and its application in guidance programs: Systematic efforts to promote personal growth*. Minneapolis, MN: Minnesota Department of Education. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman. 242-243.
- Miller, J. B. and Stiver, I. P. The healing connection: How women form relationships in therapy and in life. Boston: Beacon Press 1997.
- Miller, N. E. and Dollard, J. Social Learning and Imitation. New Haven, Conn: Yale University Press 1941.
- Mitchell, J. T. & Everly, G. S. (2001). *The basic critical incident stress management course: basic group crisis intervention (3rd ed.)*. Ellicott City, MD.: International Critical Incident Stress Foundation, Inc. p. 12.
- Mitchell, J. T., Everly, G. S., Everly, Jr., G. S. (2001) Critical Incident Stress Debriefing: An Operations Manual for Cisd, Defusing and Other Group Crisis Intervention Services (3rd Edition). Chevron Pub Corp.
- Mitchell, L. K., & Krumboltz, J. D. (1984). Social learning approach to career decision making: Krumboltz's theory. In D. Brown & L. Brooks (Eds.), *Career choice and development*. San Francisco: Jossey-Bass.
- Moldawsky, S. (1980). Psychoanalytic psychotherapy supervision. In A.K. Hess (Ed.), *Psychotherapy supervision: Therapy, research, and practice*. New York: Wiley.
- Morris J. L. (1966). Propensity of risk taking as determinant of vocational choice. *Journal of Personality and Social Psychology*, 3,328-335. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 184.
- Mosak, H. H. and Maniaci, M. P. *Tactics in Counseling and Psychotherapy* Itasca, IL: F. E. Peacock 1998.
- Munson, C.E. (1993). *Clinical Social Work Supervision*. New York: Haworth Press.
- Murphy, G. S. (1947). Personality: A biosocial approach to origins and structure. New York: Harper & Brothers. In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 216-217.
- Murray, H. A. (1938). Explorations in personality, a clinical and experimental study of fifty men of college age. New York: Oxford University Press.
- National Board of Certified Counselors (2001). "Standards for the Ethical Practice of Internet Counseling" page 3.
- National Council for Research on Women. <http://www.ncrw.org/>
- Neff, W. S. (1985). *Work and human behavior* (2nd ed.), Chicago: Aldine.
- Newman, J. L. (1993). Ethical issues in consultation. *Journal of Counseling and Development*, 72, 148-156.
- Nichols, M. P. & Schwartz, R.C., (2001). *Family Therapy Concepts and Methods*, (5th edition), Boston: Allyn & Bacon.
- O'Toole, J. (1981). *Making America work*. New York: Continuum.
- Ohlsen, M. Group counseling. New York: Holt Rinehart Winston. 1977.
- Ohlsen, M. M., Horne, A. M., & Lawe, C. F. *Group Counseling* 3rd Ed. New York: Holt, Rinehart Winston. 1988.
- Okun, B. F. (1996). *Understanding diverse families: What practitioners need to know*. New York: Guilford.
- Okun, Barbara F. (1984). *Working with Adults: Individual, Family, and Career Development*. Pacific Grove: Brooks/Cole.
- Olweus, D. (1978). *Aggression in the schools: Bullies and whipping boys*. Washington, DC: Hemisphere.
- Osborn, C.J. and Davis, T.E. (1996). "The supervision contract: Making it perfectly clear." *Clinical Supervisor*, 14(2), 121-134.
- Osgood, C.E., Suci, G.J., & Tannenbaum, P.H. (1957). *The Measurement of Meaning*. Urbana, IL: University of Illinois Press.
- Parsons, F. (1909). *Choosing a vocation*. Boston: Houghton Mifflin.
- Parten, M. (1932). Social play among preschool children. *Journal of Abnormal and Social Psychology*, 27, 243-269. In Kail and Cavanaugh Human development.
- Perls, F. *Gestalt Therapy verbatim* Moab, UT: Real People Press 1969.
- Perls, F., Hefferline, R., & Goodman, R. (1951) *Gestalt Therapy integrated: Excitement and growth in the human personality*. New York: Dell.
- Perry, W. G., Jr. (1970). Forms of intellectual and ethical development in the college years. New York: Holt, Rinehart & Winston.
- Peterson, G.W., Sampson, J.P., Jr., & Reardon, R. C., (1991). Career development and services: A cognitive approach. Pacific Grove, CA: Brooks/Cole.
- In Reardon, R. C., Lenz, J. G., Sampson, J.P., Jr., & Peterson, G.W., (2000). Career development and planning: A comprehensive approach. Pacific Grove, CA: Brooks/Cole 77-84.
- Peterson, Nadene and Gonzalez, Roberto Cortez. *The Role of Work in People's Lives* Stamford, CT: Wadsworth, 2000.
- Piaget, J. (1932). *The moral judgment of the child*. New York: Harcourt Brace Jovanovich.
- Piaget, J. (1952). *The origins of intelligence in children*. New York: International Universities Press.
- Piaget, J. (1954). *The construction of reality in the child*. New York: Basic Books.
- Piaget, J. (1962). *Play, dreams, and imitation in childhood*. New York: W. W. Norton.
- Polster, Erving. *Every Person's Life Is Worth a Novel*. New York: W. W. Norton & Company 1987.
- Pope-Davis, D.B., & Coleman, H.L.K. (Eds.) (1997). *Multicultural counseling competencies: Assessment, education and training, and supervision*. Thousand Oaks, CA: Sage.
- Powers, W. T. *Behavior: The Control of Perception*. Chicago: Aldine 1973.
- Rapaport, S. (1994, November 28). Interview. U. S. News and World Report, p. 94.
- Rapaport, R., & Rapoport, R. N. (1971). In Herr, E.L. & Cramer, S. H. (1996). *Career Guidance and Counseling Through the Lifespan - 5th ed.* New York: Longman 573-574.
- Reber, Arthur S. *Dictionary of Psychology*. New York: Penguin Books 1995.
- Remley, T.P., Jr. (1993). Consultation contracts. *Journal of Counseling and Development*, 72, 157-158.
- Remley, Theodore P. and Herlihy, Barbara (2001). *Ethical, legal, and professional issues in counseling*. Upper Saddle River, N.J.: Merrill Prentice-Hall.
- Rice, F. P. (1996). *Intimate relationships, marriages, and families*. (3rd Ed.). Mountain View, CA: Mayfield.
- Ridley, Charles R. & Mendoza Danielle W. (1993). Putting organizational effectiveness into practice; the preeminent consultation task. *Journal of Counseling and Development*, 72, 168-177.
- Robinson, B.E., Walters, L.S., & Sheen, P. (1989). Response of parents to learning that their child is homosexual and concerns over AIDS. *Journal of Homosexuality*, 18(1/2), 59-80.
- Rogers, C. (1986). Carl Rogers on the development of the person-centered approach. *Person-Centered Review*, 1(3), 257-259.
- Rogers, C.R. *Client-Centered Therapy*. Boston, MA, Houghton Mifflin, 1951.
- Rogers, C.R. *Counseling and Psychotherapy*. Boston, MA, Houghton Mifflin, 1942.
- Rogers, Carl (1961). *On becoming a person*. Boston: Houghton Mifflin.
- Rogers, Carl (1970). *Carl Rogers on encounter groups*. New York: Harper & Row.
- Rosenbaum, D. L. & Seligman, M. E. P. *Abnormal Psychology*. New York: Norton 1989.
- Rosenthal, D. and Moore, S. (1993) *Sexuality in Adolescence*. USA: Routledge.
- Rosenthal, R. and Jacobson, L. (1968) *Pygmalion in the classroom: teacher expectation and pupils' intellectual development*. New York: Holt, Rinehart & Winston.
- Rossi, A (1987) *Parenting Across the Lifespan Biosocial Dimensions*. Berlin, Germany: Aldine de Gruyter.

- Rubin, 1973, Liking and Loving [New York: Holt, Rinehart & Winston, 1973] quoted in Understanding Human Behavior and the social Environment, Zastrow and Kirst-Ashman, 1987, Nelson-Hall Publishers, Chicago, page 251.
- Salter, A., Conditioned reflex therapy. NY: Farrar, Straus, 1949.
- Salter, Andrew. The Case Against Psychoanalysis. New York: Henry Holt and Co. (1952).
- Santrock, J. W. and Yussen, S. R. Child Development 3rd Edition. Dubuque, IA: William C. Brown Publishers 1987.
- Santrock, J. W. (1993). Adolescence: An introduction (5th Ed.). Madison, WI: Brown & Benchmark.
- Santrock, John W. Life-Span Development 6th Edition. Boston MA: McGraw-Hill College 1997.
- Santrock, John W. Life-Span Development 7th Edition. Boston MA: McGraw-Hill College 1999.
- Schaefer, E. A. (1959) A circumplex model for maternal behavior. Journal of Abnormal and Social Psychology 59:226-235.
- Schein, E. (1978). The role of consultant: content expert or process facilitator? The Personnel and Guidance Journal, 56, 339-343.
- Schein, E. (1990). Organizational culture. American Psychologist, 45, 108-119.
- Schein, E. H. (1971). The Individual, The Organization, And The Career: A Conceptual Scheme. Journal of Applied Behavioral Science, 7(4), 415-416 In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman 326-328.
- Schein, E.(1969). Process Consultation: Its role in organization development. Reading, MA: Addison-Wesley.
- Schreiber, P. and Frank, E. (1983). "The use of peer supervision groups by social work clinicians." Clinical Supervisor, 1(1), 29-36.
- Schultz, B. (1982). Legal Liability in Psychotherapy. San Francisco: Jossey-Bass.
- Schutz, W. C. Encounter. In R. J. Corsini (Ed.), Current Psychotherapies. Itasca, IL: Peacock, 1973.
- Schutz, W. C. FIRO: A Three Dimensional Theory of Interpersonal Behavior. New York, NY: Rinehart, 1958.
- Schutz, W. Joy New York: Grove Press 1967.
- Scrivner, R., & Eldridge, N.S. (1995). Lesbian and gay family psychology. In R.H. Mikesell, D. Lusteran, and S.H. McDaniel (Eds). Integrating family therapy: Handbook of family psychology and systems theory (pp. 327-344). Washington, D.C.: American Psychology Association.
- Selye, H. Stress of Life. New York: McGraw-Hill, 1956.
- Shapiro, F. EMDR: The Breakthrough Therapy for Overcoming Anxiety, stress, and trauma.
- Shapiro, F. Eye Movement Desensitization and Reprocessing: Basic principles, protocols, and trauma. New York: Basic Books 1995.
- Sheehy, G. The New Passages (1995) New York: Ballantine.
- Shore, L., (1992). Stress. In L. Jones, (ED.), The encyclopedia of career change and work issues. Phoenix, AZ: Onyx Press 138-51. In Peterson, N. & Gonzalez, R. C. (2000). The role of work in people's lives, Applied career counseling and vocational psychology. Belmont, CA: Brooks/Cole 352.
- Shulman, L. (1982). Skills of Supervision and Staff Management. Itasca, IL: F. E. Peacock.
- Shuman, Daniel W. (1997). Law and Mental Health Professionals: Texas. 2nd ed. Washington: American Psychological Association.
- Siegler, R. A. (1998). Children's thinking (3rd ed.). Upper Saddle River, NJ: Prentice Hall.
- Skinner, B. F. (1957). Verbal behavior. New York: Appleton-Century-Crofts.
- Slakter, M. J., & Cramer, S. H. (1969). Risk-taking and vocational or curriculum choice. Vocational Guidance Quarterly, 17(2) 127-132. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman 184.
- Solomon, R.L. (1980). The opponent-process theory of acquired motivation: The costs of pleasure and the benefits of pain. American Psychologist, 35, 691-712.
- Sonnenfeld, J. A., (1989). Career system profiles and strategic staffing. In M. B. Arthur, D. T. Hall, & B. S. Lawrence (Eds.), Handbook of career theory 202-224. In Sharf, R. S., (1997). Applying Career Development Theory to Counseling. Pacific Grove, CA: Brooks/Cole Publishing Company 404.
- Steiner, C. Scripts People Live. New York: Grove Press, Inc. 1974.
- Sternberg, R. J. (1986). Intelligence applied. San Diego: Harcourt Brace Jovanovich.
- Stoltenberg, C, McNeill B., & Delworth, U. (1998). IDM supervision: an integrated developmental model for supervising counselors and therapists. San Francisco: Jossey-Bass.
- Stone, Michael H. Healing the Mind. New York: W. W. Norton & Company 1997.
- Stuart, Richard (1980) Helping Couples Change: A Social Learning Approach to Marital Health, New York, The Guilford Press.
- Sue, D. W. and Sue, David. Counseling the Culturally Different 3rd Edition New York: John Wiley & Sons Inc. 1999.
- Sue, David; Sue, Derald; and Sue, Stanley. Understanding Abnormal Behavior Boston MA: Houghton Mifflin Company 1990.
- Sullivan, H. S. (1953). The interpersonal theory of psychiatry. New York: Norton.
- Super, D. E. (1969) The natural history of a study of lives and of vocations. Perspectives on Education. 2.13-22 In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman 232.
- Super, D. E. (1980). A life-span, life space approach to career development. Journal of Vocational Behavior, 16(30) 282-298. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman 235-237.
- Super, D. E. (1990). A Life-span, life-space approach to career development. In D. Brown, L. Brooks, & Assoc. (Eds.), Career choice and development: Applying contemporary theories to practice (2nd ed) 197-261. In Sharf, R. S., (1997). Applying Career Development Theory to Counseling. Pacific Grove, CA: Brooks/Cole Publishing Company 149.
- Super, D. E., (1953) Transition: From Vocational Guidance to Counseling Psychology. Journal of Counseling Psychology, 3, 2-9.
- Super, D. E., (1955) A Theory of Vocational Development. American Psychologist, 8, 185-190.
- Super, D. E., (1984). Career and life development. In D. Brown, & L. Brooks (Eds.) Career choice and development: applying contemporary approaches to practice. San Francisco: Jossey-Bass. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman 232.
- Sutton, C., & Broken Nose, M. (1996). American Indian families: An overview. In M. McGoldrick, J. Giordano, & J. Pearce (Eds.), Ethnicity & Family Therapy, 2nd edition (pp. 31-44). New York: Guilford Press.
- The Dictionary of Family Psychology and Family Therapy, 2nd Edition. Sauber, L'Abate, Weeks, and Buchanan. SAGE Publications, Newbury Park, 1993, page 104.
- The Dictionary of Family Psychology and Family Therapy, 2nd Edition. Sauber, L'Abate, Weeks, and Buchanan. SAGE Publications, Newbury Park, 1993, page 76.
- The Dictionary of Family Psychology and Family Therapy, 2nd Edition. Sauber, L'Abate, Weeks, and Buchanan. SAGE Publications, Newbury Park, 1993, pages 90-91.
- Thomas, A. & Chess, S. (1991). Temperament in adolescence and its functional significance. In R. M. Lerner, A. C. Petersen, & J. Brooks-Gunn (Eds.), Encyclopedia of adolescence (Vol. 2). New York: Garland.
- Thompson, A. S., & Lindeman, R. H. (1981) Career Development Inventory: Vol. 1. In Sharf, R. S., (1997). Applying Career Development Theory to Counseling. Pacific Grove, CA: Brooks/Cole Publishing Company 186-189.
- Tortora, Gerard J. and Grabowski, Sandra Reynolds. Principles of Anatomy and Physiology New York: Harper Collins College Publishers 1993.
- Truax, C. B. and Carkhuff, R. R. (1967). Toward effective counseling and psychotherapy: Training and practice. Chicago: Aldine-Atherton.
- Tuckman, B. W. (1965). Developmental Sequence in Small Groups. Psychological Bulletin, 63(6), 384-399.
- Tuckman, B. W., & Jensen, M.A. (1977). Stages of small group development revisited. Group and Organization Studies, 2, 419-427.
- Vacc, N. A., & Loesch, L. (2000). Professional orientation to counseling. (3rd ed.). Philadelphia, PA: Brunner-Routledge.
- Van Hoose, W.H., & Worth, M.R. (1982). Counseling adults: A developmental approach. Monterey, CA: Brooks/Cole.

- Vroom, V. H. (1964). *Work and Motivation* New York: Wiley. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman. 186.
- Wachter, M. L., (1974). Primary and secondary labor markets: A critique of the dual approach. *Brookings Papers on Economic Activity*, e. 637-693. In Sharf, R. S., (1997). Applying Career Development Theory to Counseling. Pacific Grove, CA: Brooks/Cole Publishing Company. 406.
- Walsh, W.M., & McGraw, J.A. (2002) *Essentials of Family Therapy: A structured summary of nine approaches (2nd ed.)*. Denver, CO: Love Publishing.
- Walz, G. R. & Benjamin, L. (1984). A systems approach to career guidance. *The Vocational Guidance Quarterly*, 33(1), 26-34. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman 47.
- Watson, Robert I. *Basic Writings in the History of Psychology*. New York: Oxford University Press 1979.
- Webster's Collegiate Dictionary, 10th Edition, Springfield, MA, G & C Merriam Co., 1998.
- Welfel, E.R. (1998). Ethics in counseling and psychotherapy. Pacific Grove, CA.: Brooks/Cole Publishing.
- Wilcox-Matthew, L., & Minor C. W. (1989). The dual career couple: Concerns, benefits, and counseling implications. *Journal of counseling and Development*, 68, 194-198. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman 575.
- Williams, Antony (1995). *Visual and active supervision*. New York: W.W. Norton & Co.
- Winnicott, D. W. *Holding and Interpretation: Fragment of Analysis*. New York: Grove Press 1986.
- Wittmer, P. J., & Loesch, L. C. (1986). Professional orientation. In M. D. Lewis, R. L. Hayes, & J. A. Lewis (Eds.), *An introduction to the counseling profession* (pp. 301-330). Itasca, IL: Peacock.
- Wolpe, J. *The Practice of Behavior Therapy*. New York: Pergamon Press, 1969.
- Worthington, E.L. (1987). "Changes in supervision as counselors and supervisors gain experience: a review." *Professional Psychology: Research and Practice*, 18, 189-208.
- Wubbolding, R. E. *Reality Therapy for the 21st Century*. Muncie, IN: Accelerated Development (Taylor & Francis) 2000.
- Wubbolding, R.E. (1991). Professional issues: consultation and ethics part II. *Journal of Reality Therapy*, 10, 55-59.
- Yalom, Irvin D. *The Theory and Practice of Group Psychotherapy* 4th edition. New York: Basic Books 1985, 1995.
- Yost & Corbishley (1987). Career counseling: A psychological approach. San Francisco: Jossey-Bass. In Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman. 603.
- Zastrow, C. and Kirst-Ashman, K. (1987). *Understanding Human Behavior and the Social Environment*. Chicago: Nelson-Hall.
- Ziller, R. C. (1957). Vocational choice and utility for risk. *Journal of Counseling Psychology*, 4, 61-64 Herr, E.L. & Cramer, S. H. (1996). Career Guidance and Counseling Through the Lifespan - 5th ed. New York: Longman 184.
- Zins, Joseph E. (1993). Enhancing consultee problem-solving skills in consultative interactions. *Journal of Counseling and Development*, 72, 185-190.